

MEDICAL BOARD OF CALIFORNIA

JOINT LEGISLATIVE SUNSET REVIEW COMMITTEE 2002 SUNSET REVIEW REPORT

Four Year Overview of the Board's Regulatory Program, Board's Response to Issues and Recommendations from Previous Sunset Review, Background Paper for the 2001 Public Hearing, and Final Recommendations of the Joint Committee and the Department of Consumer Affairs

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1.

OVERVIEW OF THE CURRENT REGULATORY PROGRAM

BACKGROUND AND DESCRIPTION OF THE BOARD AND THE PROFESSION

The Medical Board of California's primary responsibility is to protect consumers through the licensing and regulation of physicians. It is a 19 member board consisting of 12 physicians and seven public members, with 17 appointed by the Governor and two appointed by the Legislature. The Board has a long and rich history and is constantly changing to keep pace with the evolution of the medical profession and practice. While the method of regulating medicine is often the subject of debate, the desirability of its regulation is not. The Medical Board provides consumer protection through a number of methods which will be discussed in this report, and which were designed to ensure compliance with minimum legal standards. The Board serves as a deterrent to those who might be drawn to violate these standards resulting in harm to their patients, while seeking to use its resources to establish appropriate guidelines in those areas of practice that are currently unsettled.

History of the Medical Board of California and Landmark Legislation

The Medical Board has its roots in a number of previous bodies. The first regulatory body in the state began in 1876, with the passage of the first Medical Practices Act. In 1878 three separate boards were established to represent the systems in vogue at that time: the California Medical Society Board, the Eclectic Medical Society Board, and the Homeopathic Medical Society Board. In 1901, the Medical Practices Act was completely rewritten, and the three boards became one Board of Examiners with nine members, representatives appointed from the three societies. In 1907, the Legislature again restructured the Board to consist of 11 members, appointed by the Governor. In 1913, a revolving fund was created to fund the Board's activities, and later, in 1917, re-registration fees were established to pay for the ongoing costs of operations.

From 1950 to 1976, the Board continued to expand its role in protecting the public beyond medical licensing examinations and discipline. The role was expanded to oversee the licensing of various allied health professionals, such as physical therapists, podiatrists, and psychologists. District Review Committees, also appointed by the Governor, were established to hear disciplinary cases, and the concept of continuing medical education was initiated.

By far, 1976 was the most pivotal year for the Board, and changes to the Medical Practices Act basically created our modern day Medical Board. In the 1970s, the medical profession and patients in some regions were severely impacted by the rise in malpractice insurance costs. By 1975, the problem of rising costs created a crisis for some specialties, especially obstetrics and other high-risk specialties. As an example, during that period there were no physicians in Butte County that would practice obstetrics, forcing patients to have their babies delivered outside their county. For that reason, then Governor Jerry Brown called the Legislature back to an Extraordinary session to grapple with the malpractice problem and create a reform.

Assemblyman Barry Keene took the helm to author AB 1xx, the Medical Injury Compensation Reform Act, broadly known as MICRA. The Act created the cap of \$250,000 for punitive damages in malpractice suits, a cap that remains to this day and is unique to civil actions brought against professional licensees. In addition, attorney contingency fees were limited.

To reach such a sweeping agreement, however, the medical profession had to make concessions too. The concession made was a new, improved, better equipped, less physician oriented and more publicly minded Medical Board. The Board would now have considerable public representation. The previous board had only one non-physician out of 11, which was changed to a board membership of 19 with 12 physicians and 7 non-physician public members. In addition, the Board would have its own enforcement team, trained peace officers that would investigate complaints against doctors. Part of the Act required mandatory reporting to the Board of hospital discipline and malpractice awards.

The rationale of this compromise was simple. Punitive damages do not remedy injury. Prevention of malpractice that could occur, due to a more efficient Medical Board, would save lives and injury, and, after much debate, the bill was passed and a new Board was born. The Board remained essentially the same until 1990, when greater reforms to the Board's enforcement authority were initiated.

The foundation of the reforms was SB 2375, Chaptered in 1990. This bill was a result of a number of disturbing cases, dismal statistics of disciplinary action taken against physicians, and the perception that the Board was extremely lenient on bad physicians, which put the public at risk. The Center for Public Interest Law had authored the report *Physician Discipline in California: A Code Blue Emergency* which called the Board Amoribund@ and drew the attention of the Legislature, the press, and the Board.

SB 2375, usually just called Athe Presley Bill@ or APresley,@ established a number of public protection initiatives and strengthened the Board ' s authority. Among them were requiring coroners to report to the Board when deaths were a result of physician involvement and county courts to report felony convictions of doctors, as well as giving the authority to the board to investigate malpractice awards. It also raised fines for hospitals failing to report peer review action, and required licensing applicants to supply fingerprints. In an effort to speed-up the process, it required the Board to set a goal of 6 months to process complaints.

Most importantly, however, were the reforms that had major impact on disciplinary action and the handling of complaints. Pre-Presley, the prosecution of Board cases were handled by the Attorney General ' s Licensing Section. The Board had to compete with a host of other agencies for their services, and deputy attorneys of that division might be handling a toaster repairman one day, an architect the next, followed by an accountant, and, if their resources allowed, a physician disciplinary action. After Presley, the Board ' s cases would be handled by a specialized unit, the Health Quality Enforcement Section (HQUES), headed by its own Senior Assistant Attorney General, dedicated to ONLY medical cases. In addition, the Medical Quality Hearing Panel within the Office of Administrative Hearings was created, so that the administrative judges hearing medical cases were specially trained and experienced in Medical Board disciplinary matters.

The establishment of the HQUES was extremely important. Medical cases are more complex than other disciplinary cases, and as a result, more costly to prosecute. When thrown into a general pool, it was not surprising that the simpler, more expeditious cases tended to be worked first, leaving the more difficult physician cases waiting for the deputies to have sufficient time. Physicians, to a great extent, have the monetary resources to hire specialized attorneys to dedicate themselves completely to their defense. To balance the public interest, the Medical Board needed specialists too, those with expertise with medical cases. Before the establishment of the HQUES, many of the Board ' s cases languished before being scheduled for hearing, or even being filed. To illustrate, when the Section was established in 1991, over 1,000 of the Board ' s cases were backlogged C these

cases had not even been filed. To put this in perspective, today, most cases are filed within two months of transmittal to the Office of the Attorney General.

Another major reform was the establishment of the Interim Suspension Order, or ISO. This action is reserved for physicians who pose an immediate danger to the public if they are allowed to continue to practice while charges are pending. Before Presley, the only avenue to obtain such an order was through Superior Court for a Temporary Restraining Order, which would mean the matter would have to be heard in Superior Court, while pursuing licensing restrictions or revocation through the Administrative Procedure. Now, the Deputy Attorney General may have the case heard in an administrative hearing, not significantly different than routine disciplinary cases. While ISOs do have a number of restrictions and requirements within the administrative process, having this tool has no doubt protected the public from the most dangerous, and, in some cases, predatory doctors.

This landmark bill not only made a number of important changes of substance, but was also symbolic of the frustration and disappointment of lawmakers as well as the public in the Board's apparent bias to put the interests of physicians over patients. The perception was, and it tended to be backed-up by the disciplinary penalties imposed, that the Board was willing to extend second, third, and fourth chances to physicians, to the detriment of their patients. Symbolic of this new day in physician regulation, was the change in the Division of Medical Quality's purpose. Prior to Presley, the law required the Board to take action to aid in the rehabilitation of the *physician*. After Presley, where a conflict in physician rehabilitation and public protection exists, the *public* became the Board's highest priority. To ensure that the Board took this legislation and its mission seriously, the bill also required that the Board annually report to the Legislature the actions taken in the previous year. The Board publishes an annual report to the Legislature in October, in which it presents a series of data that can be assessed to evaluate the actions which have been pursued by the Board in its effort to protect patients.

In 1993, Senator Presley authored a bill to refine the reforms in his original legislation. This time, the structure of Board, oversight, and money were the focus.

SB 916, or APresley II,[@] eliminated the Division of Allied Health and assigned its duties to Division of Licensing, and expanded the membership of the Division of Medical Quality from seven to twelve. In addition, it eliminated the Medical Quality Review Panels, which really were no longer practical. (When the MQRCs were established, disciplinary hearings were generally one to three days. As most

hearings are much longer now, as long as a month, these voluntary panels, mostly made up of practicing physicians, could not be effectively used.)

As far as oversight, SB 916 required the State Auditor to perform a complete audit of the Board's disciplinary system, gave the Department of Consumer Affairs the authority to audit and review the handling of complaints and discipline rendered by the Board, and required public representation on Diversion Evaluation Committees. In addition, it established more public disclosure of information on doctors, requiring that the Board tell the public about a physician's disciplinary record in California and other jurisdictions, as well as malpractice judgments, specific hospital peer review discipline, and criminal convictions. Possibly most importantly, it raised the biennial renewal fee ceiling to \$600, which was desperately needed to pay for managing the increased workload.

The bill also made practicing medicine while under the influence of alcohol or drugs a crime, established the penalty of a Public Letter of Reprimand,[@] and required medical societies to refer those with complaints about doctors to the Medical Board, among other, less dramatic reforms.

In 1994, SB 1775, often called a Presley III,[@] was passed. This time, the legislation was more focused on assisting the Board in meeting the mandates of previous law. It repealed a number of technical requirements that had outlived their usefulness but diverted resources, and made technical changes to a number of codes for clarification and simplification. Most importantly, the bill required the Office of Administrative Hearings to prepare its decisions within 30 days of the administrative hearing. At the time, delays in disciplinary action could be dramatic --- in some offices, the OAH was taking up to nine months to hand down a decision to the Board. Because of this change, today, virtually all decisions are completed within 30 days.

SB 1775 was the final Presley legislation addressing the Medical Board, and there have been no bills of such sweeping reforms addressing how the Medical Board investigates and disciplines physicians since. Those who are concerned with the quality of the regulatory process owe the Senator their gratitude for his leadership, the Center for Public Interest Law for sounding the alarm, and the California Medical Association at that time for making a number of concessions which were unpopular with the profession but were in the interest of patient safety.

The Board, with few exceptions, has jurisdiction over the professions, not treatment options, facilities, insurance or business practices, reimbursement rates, or civil malpractice matters. The Board is not the FDA, the Health Department,

the Department of Managed Healthcare, or the Insurance Commission. While some issues concerning other jurisdictions may overlap with the Medical Board, the Board's primary role is to oversee the conduct of its licensees. The reforms over the years have made it clear that only the Medical Board is responsible for oversight of physicians' conduct, and without a strong Board vigorously fulfilling its mandate, there is little consumer protection. While peer review, medical schools, accreditation agencies and the courts do their part to function as deterrents to bad practice, the Medical Board alone can legally put an end to the conduct of dangerous practitioners.

Today's Board Composition

Today the Board is comprised of 19 members, including 12 physicians and seven public members. Appointments are made to one of the two Divisions of the Board, the Division of Licensing or the Division of Medical Quality. The Division of Licensing has seven members (four physicians and three public members), six of whom are appointed by the Governor and one appointed by the Senate Pro-Tem. The Division of Medical Quality has 12 members, including eight physicians and four public members, 11 appointed by the Governor and one appointed by the Assembly Speaker.

Prior to 1994, the Board had three divisions instead of two. The Division of Licensing (DOL), the Division of Medical Quality (DMQ), and the Division of Allied Health Professions. The DMQ and DOL existed much as they do today, but the Division of Allied Health Professions was charged with the oversight of the professions directly under the Board's jurisdiction and the various allied health examining committees under its purview. In 1994, the Division of Allied Health was repealed, and the five members on that Division were reassigned to DOL and DMQ.

THE BOARD'S PURPOSE AND JURISDICTION

The primary purpose of the Medical Board is to protect consumers, much like the other boards and committees under the umbrella agency of the Department of Consumer Affairs. While the Board does engage in a number of activities to rehabilitate, educate, or assist physicians, the primary purpose of the Medical Board is to benefit patients, through the proper licensing of physicians and surgeons and through enforcement of the Medical Practice Act. An appointment to the Medical Board is a service performed for the public good.

Division of Licensing

Licensing of Physicians:

In order to protect consumers, the essential role of the Board is to license and discipline physicians. Members of the Division of Licensing do their part by licensing only physicians who meet the rigorous educational and examination standards. As in all of the Boards activities, the decision to license physicians is made purely by legal standard. (For specific information on the licensing of physicians, please see ALicensing Requirements@ on page 37.)

In service to the public and the profession, another vital role the Division of Licensing plays is that of clearing-house for information on physicians. The Licensing program processes thousands of requests for licensing verification each month, not including all of the information provided to users of the Internet. Hospitals depend on the information provided for credentialing of their staff, and the public is able to check on their physicians as well.

Affiliated Healing Arts:

Since the repeal of the Division of Allied Health Professions, the Division of Licensing also is responsible for licensing and registering a number of affiliated healing arts professions. The Division is directly responsible for the licensing or registration of:

Licensed Midwives (not to be confused with Certified Nurse Midwives, who are registered nurses under the jurisdiction of the Board of Registered Nursing), Registered Dispensing Opticians, and Research Psychoanalysts, as well as a regulatory role over unlicensed Medical Assistants. (For specific data on these licensees and their licensing or practice requirements, see pages 42 through 48.) In addition, the Division has an oversight role over some other professions, such as Acupuncturists, Physician Assistants, and Physical Therapists.

The Division also is responsible for a number of other activities, such as approving training of foreign fellows and faculty, specialty boards, and accreditation agencies.

Approval of Licensing Exemptions for Foreign-trained Fellows and Faculty:

Business & Professions Code Sections 2111, 2112, and 2113 provide licensing exemptions to foreign-trained research and training fellows and faculty. Division of Licensing must approve these fellowships in order for these fellows to legally participate. The Division members regularly visit California medical schools to

evaluate the fellowship training programs and to ensure that the activities of the participants fall within the parameter of the fellowship restrictions.

Specialty Boards:

In 1990, SB 2036 (McCorquodale), a bill sponsored by the California Society of Plastic Surgeons, among others, sought to prohibit physicians from advertising board certification who were certified by Aweekend@ boards, or other entities that were not genuine certifying agents. At the time, this bill was referred to as the Abogus board@ bill. The law (Business & Professions Code Section 651(h)(5)(A)&(B)) prohibits physicians from advertising that they are Aboard certified@ unless they are certified by an American Board of Medical Specialties (ABMS) specialty board, or a board approved by the Medical Board of California.

This law has been problematic and the subject of four lawsuits since its passage. Despite the problems, the Board members over the years have attempted to administer this law in a manner that makes it meaningful and helpful to consumers. Since the regulations were adopted, the Division of Licensing has reviewed a number of specialty board applications.

Specialty boards that have been approved by the Medical Board are:

1. The American Board of Facial Plastic & Reconstructive Surgery
2. The American Board of Pain Medicine
3. The American Board of Sleep Medicine

Specialty boards that applied, but were not approved are:

1. The American Academy of Pain Management
2. The American Board of Cosmetic Surgery

For more information about this law, please see Appendices VI, ASpecialty Boards.@

Approval of Accreditation Agencies - Accreditation of Outpatient Surgery Settings:

The Medical Board generally has no jurisdiction over facilities. Facilities, such as hospitals, clinics, ambulatory surgical centers, and certain other facilities, are under the purview of the Department of Health Services, Licensing and Certification Division. The one exception to this is certain outpatient surgery settings engaging in some practices defined in law, performed outside of hospitals and certified facilities.

To provide oversight of these settings, California has had an Aoutpatient surgery@ law on the books since January 1, 1995, and it went into effect for physicians on July 1, 1996. AB 595, authored by then Assemblywoman Jackie Speier, was Board-sponsored legislation to provide some safeguards in these previously unregulated settings.

In summary, California law requires that surgery performed under a certain specified level of anesthesia, if not performed in a licensed hospital or surgery center, be done in an accredited facility. The Medical Board does not perform the accreditation, but instead delegates the accreditation to agencies that it certifies. Currently there are four accreditation agencies approved by the Medical Board: 1) American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF); 2) Accreditation Association for Ambulatory Health Care (AAAHC); 3)Joint Commission on Accreditation of Health Care Organizations (JCAHCO), and; 4) Institute for Medical Quality (IMQ).

For more information about this law, please see Appendices VII, AOutpatient Surgery.@

Licensing Data Tables

Total Licensees:	97/98	98/99	99/00	00/01
Physician & Surgeon	105,528	106,909	108,068	109,289
Registered Dispensing Optician Firm	1,391	1,334	1,252	1,183
Contact Lens Dispenser	588	546	488	464
Spectacle Lens Dispenser	2,259	2,141	1,911	1,813
Research Psychoanalyst	68	69	65	72
Licensed Midwife	81	100	110	112
Licenses Issued:	97/98	98/99	99/00	00/01
Physician & Surgeon	3,684	4,043	4,043	3,777
Registered Dispensing Optician Firm	90	225	46	54
Contact Lens Dispenser	44	21	20	14

Spectacle Lens Dispenser	209	128	96	90
Research Psychoanalyst	1	1	0	6
Licensed Midwife	41	23	12	12
Licenses Renewed:	97/98	98/99	99/00	00/01
Physician & Surgeon	50,693	51,070	51,951	51,926
Registered Dispensing Optician Firm	699	751	535	583
Contact Lens Dispenser	72	64	242	195
Spectacle Lens Dispenser	953	905	930	757
Research Psychoanalyst	68	1	64	3
Licensed Midwife	44	44	54	59

Physician & Surgeon	97/98	98/99	99/00	00/01
Total Licensed:	105,528	106,909	108,068	109,289
California	80,341	81,762	82,872	84,675
Out-of-state	25,187	25,147	25,196	24,614
Applications Received	4,491	4,454	4,644	5,039
Applications* Denied	3	2	2	7
Licenses Issued	3,684	4,043	4,043	3,777
Renewals Issued	50,693	51,070	51,951	51,926
Statement of Issues Filed	4	8	4	11
Statement of Issues Withdrawn	0	0	1	0
Licenses Denied*	3	6	2	3

*Does not include probationary certs

Registered Dispensing Optician Firm	97/98	98/99	99/00	00/01
Total Licensed:	1,391	1,334	1,252	1,183
California*				1,177
Out of State*				6
Applications Received	364	206	229	87
Applications Denied	2	2	1	0
Licenses Issued	90	225	46	54
Renewals Issued	699	751	535	583
Statement of Issues Filed	0	0	0	0

Statement of Issues Withdrawn	0	0	0	0
Licenses Denied	0	0	0	0

Contact Lens Dispenser	97/98	98/99	99/00	00/01
Total Licensed: California* Out-of-state*	588	546	488	464 455 9
Applications Received	34	18	25	17
Applications Denied	0	0	0	0
Licenses Issued	44	21	20	14
Renewals Issued	72	64	242	195
Statement of Issues Filed	0	0	0	0
Statement of Issues Withdrawn	0	0	0	0
Licenses Denied	0	0	0	0

- California and Out-of-State Data not available for 97/98 through 99/00 years.

Spectacle Lens Dispenser	97/98	98/99	99/00	00/01
Total Licensed: California* Out-of-state*	2,259	2,141	1,911	1,813 1,770 43
Applications Received	205	124	131	105
Applications Denied	0	0	0	2
Licenses Issued	209	128	96	90
Renewals Issued	953	905	930	757
Statement of Issues Filed	0	0	1	1
Statement of Issues Withdrawn	0	0	0	0
Licenses Denied	0	0	0	0

Research Psychoanalyst	97/98	98/99	99/00	00/01
Total Licensed: California* Out-of-state*	68	69	65	72 68 4
Applications Received	1	2	5	3
Applications Denied	0	1	3	0

Licenses Issued	1	1	0	6
Renewals Issued**	68	1	64	3
Statement of Issues Filed	0	0	1	0
Statement of Issues Withdrawn	0	0	1	0
Licenses Denied	0	0	0	0

Licensed Midwife	97/98	98/99	99/00	00/01
Total Licensed:	81	100	110	112
California*				103
Out-of-state*				9
Applications Received	44	23	12	13
Applications Denied	0	0	0	0
Licenses Issued	41	23	12	12
Renewals Issued	44	44	54	59
Statement of Issues Filed	0	0	0	0
Statement of Issues Withdrawn	0	0	0	0
Licenses Denied	0	0	0	0

* Data not available for 97/98 through 99/00 years. ** Renewed biennially; 3 have renewal dates in opposite year

The Division of Medical Quality

Disciplining physicians is the task of members of the Division of Medical Quality. The disciplining of physicians is the most controversial activity of the Board to the profession, while the lack of discipline of physicians is the most controversial issue to the public-at-large.

The Boards enforcement program receives over 10,000 complaints each year, of which about 2,000 cases are transmitted to field investigators for full investigation that may lead to formal disciplinary action.

The Division of Medical Quality renders discipline within the legal confines of the law. Physicians are charged with violations of the Medical Practice Act through a legal filing by the Deputy Attorneys General, the case is heard by an Administrative Law Judge, and the DMQ either adopts or rejects the proposed decision handed down by the judge. While most of these cases begin with a filing of an accusation to begin the process of disciplining a physician for violations, in the instances where a practitioner poses an immediate threat to the public, the

Medical Board may seek an Interim Suspension Order through the Office of Administrative Law or a Temporary Restraining Order through Superior Court to immediately suspend or restrict a physician's practice while charges are pending.

In the majority of cases, physicians agree to terms in a settlement, thereby reducing the number of cases that would otherwise require a lengthy hearing process. (For specific information regarding the Board's disciplinary actions, please see AEnforcement Activity@ beginning on page 49.)

While the Administrative Law Judge hears the case and hands down a proposed decision or opposing counsels work-out a settlement, one of the more important functions of the Division of Medical Quality is to provide oversight of this process. The DMQ reviews every case, whether it has been through the hearing process or is a result of a settlement, to evaluate whether the facts were accurately decided, and, whether or not the punishment is appropriate to the violation. Most importantly, it is the DMQ's task to judge whether or not the decision or settlement provides adequate protection to the public.

The DMQ members review all decisions and settlements. Specifically, they evaluate them on the credibility of the facts and witnesses, that the law and standards of practice are interpreted correctly, that the penalty fits within the disciplinary guidelines and that any deviation from those guidelines is adequately explained, and, if probation is granted, the terms and conditions are appropriate to protect the public. If a proposed decision or settlement is not adopted, then the members have found that these specific conditions have not been met. If the members are considering non-adopting or modifying a decision or settlement, an opportunity is given to the Deputy Attorney General and the defense counsel to present oral arguments to the members. In the cases where a hearing has been held and a proposed decision is being considered, the members read the entire transcript of the hearing and review all exhibits introduced as evidence.

Committees of the Board

The Medical Boards only statutorily defined bodies are the Division of Medical Quality and the Division of Licensing. While these are the only bodies with legal authority to take formal action, the Board often appoints advisory committees to study topics of interest and importance to medical practice and patient safety. Committees have been formed to advise the Board and Divisions on the subjects of outpatient surgery, telemedicine, on-line prescribing of drugs, assuring continued competency of licensed physicians, medical experts, the physician diversion program, cosmetic and plastic surgery, and, most recently, complementary and

alternative medicine. Although these committees do not possess any authority to take formal action, the outcomes of their work are brought to the relevant divisions or the entire Board and have proved useful in developing legislative and regulatory proposals, as well as revision of the Boards operations to bring about greater efficiency and effectiveness.

Elements of Healthcare Delivery and Regulation Performed by Other Agencies Outside of the Jurisdiction of the Medical Board

While the Medical Boards role in consumer protection is important, it only has authority over those elements of healthcare under its statutory jurisdiction. Other elements which certainly impact patient care often fall under other governmental or private agencies. Generally, the Medical Board does not have jurisdiction over facilities, staffing, standards of practice, or insurance; nor does it drive medical education curriculums. Just as it is important to know over what elements the Board has jurisdiction, its also important to know where the responsibility and jurisdiction fall for the other various elements of healthcare not under its jurisdiction.

Facility Licensing and Hospitals: Facility certification for Medicare participation is under the jurisdiction of the Department of Health Services, Licensing and Certification Branch. Accreditation of Hospitals, medical groups, and other facilities is under the jurisdiction of various private agencies, such as the Joint Commission on Accreditation of Hospitals and Health Systems (JCAHO), the National Council for Quality Assurance (NCQA), among others.

Staffing: Who does what in facilities, if done within the legally defined scope of practice, is not the jurisdiction of the Medical Board. The Board sets no standards for credentialing of hospital staff, or who is qualified to perform what tasks or who may be granted privileges. Hospitals fall under the Health & Safety Code and therefore the Department of Health Services, which is also influenced by the accreditation standards of various private agencies or payers, such as the Joint Commission.

Standards of practice and appropriate treatment: The standard for medical care as it relates to professional conduct is determined by the medical community, not the Board. This has been established in statute and in case law. The Board does not determine the appropriate treatment for any disease or condition, nor does it have the authority to determine the efficacy or safety of any drug, device, or treatment. The Federal Drug Administration is the entity that has jurisdiction over drugs and medical devices. While the Board, through its disciplinary actions, may determine on a case-by-case basis that a certain treatment was an extreme

departure from the community standard of care, and therefore negligent or incompetent, these decisions are relevant only to events and circumstances in that case and do not have global impact to all who would use that treatment or drug.

Health Insurance Plans and Medicare and MediCal: Issues of insurance fall under a number of other agencies outside of the Board. Within California Government, the Commissioner of Insurance has jurisdiction over indemnity-style health insurance, the Department of Managed Healthcare oversees HMOs, and the Department of Health Services administers the MediCal program. On the Federal level, the Health & Human Services Agency has jurisdiction over Medicare, and the Department of Justice is the prosecutor of fraud within that program.

Medical Education and Curriculum outside of the Licensing Requirements:

The Division of Licensing ensures that all who are granted a license to practice medicine meet all of the legally mandated requirements. While California Law specifically addresses certain coursework as requirements for licensure, the Division of Licensing does not have jurisdiction over what is taught by medical schools or postgraduate training programs. A number of nationally recognized, private agencies are responsible for determining medical curricula. The following private, non-profit agencies are responsible for developing and overseeing various elements of the medical education in the United States:

LCME: The Liaison Council for Medical Education sets standards for accredited medical schools in the United States.

ACGME: The Accreditation Council for Graduate Medical Education accredits postgraduate training programs, including specialty training programs required for board certification by the ABMS.

ABMS: American Board of Medical Specialties sets training and examination requirements for specialty board certification.

ACCME: Accreditation Council for Continuing Medical Education sets standards for continuing medical education.

Specialty practice standards and interests of the profession: The ABMS specialty boards set certification standards for specialty training and examination, while the affiliated specialty societies represent the interests of those specialties. The Medical Board sets no standards for specialty training and certification, nor is its role to represent the interests of specialists. While the Division of Licensing does grant equivalency status for advertising to some non-ABMS specialty boards, it is not its role to design or construct training. In California and all 50 states in the Union, specialty practice and the training and certification of specialists are under the purview of the nationally recognized specialty boards under the ABMS.

Specialty societies represent the professional and economic interests of their members. While sometimes issues of economic interest have public protection implications, historically the Board has not addressed matters of finance or the business of medicine. Generally, it is the role of the societies to look after their members' interests, while it is the Board's role to look after the interests of the consumer.

CHANGES TO THE BOARD SINCE THE LAST SUNSET REVIEW

Legislative Changes

Since the last Sunset Review, there have been a number of legislative changes and mandates that affect the Board and consumers. Bills to address the information provided to the public, physician education, doctor discipline, pain management and outpatient surgery, among others, all have had their impact on health care and consumers. Some of the more significant bills passed were:

Information for the Public:

AB 103 (Figueroa, Chapter 359, Statutes of 1997), required that the following information be made available to consumers on the Board's Web site: (1) status of the physician's license; (2) out-of-state discipline; (3) felony convictions; (4) accusations; (5) malpractice judgments or arbitration awards; (6) hospital disciplinary actions resulting in termination or revocation of hospital privileges for medical disciplinary cause or reason; (7) links to other Web sites that provide information on board certification, healthcare service plans, and health insurers. The Board added this information to its Web site in 1998.

AB 833 (Ortiz, Chapter 754, Statutes of 1997), requires that doctors performing an annual gynecological examination provide patients a published summary of a description of the symptoms and appropriate methods of diagnoses for gynecological cancers. Publications developed by nationally recognized cancer organizations are acceptable. It also required the Department of Health Services to develop a plan for the development and distribution of these materials. DHS publishes a brochure entitled *A Gynecologic Cancers...What Women Need to Know*.@ The Board has informed its licensed physicians of this requirement through the Action

Report, @ most recently in the July 2001 issue, explaining the law, how to order pamphlets, and the languages in which they are published.

SB 1 (Burton, Chapter 11, Statutes of 1997), established the AGrant H. Kenyon Prostate Cancer Detection Act, @ requires a physician examining a patients prostate to provide information about the availability of appropriate diagnostic procedures, including the prostate specific antigen test (PSA), to patients of certain age, history or symptoms. The Medical Board makes AWhat You Need to Know About Prostate Cancer@ booklets available to physicians upon request. The Board has informed its licensed physicians of this requirement through the AAction Report, @ most recently in the July 2001 issue.

Licensing & Continuing Medical Education:

AB 3171 (Martinez, Chapter 382, Statutes of 1996), requires the Division of Licensing to consider allowing credit for courses in end-of-life issues to meet the mandatory continuing medical education requirement for license renewal. (Courses in end-of-life issues accredited for Acategory one@ credit are approved to meet the continuing education requirements.) The Division grants credit for courses in end-of-life issues towards meeting the continuing medical education requirement.

AB 523 (Lempert, Chapter 332, Statutes of 1997), addressed a need expressed by the medical schools to allow the Board to issue a special permit to physicians hired to teach at medical schools. This law permits medical schools to hire faculty members meeting the criteria of Aacademically eminent@, but who are not licensed to practice in California. These permit holders pay the same fees as licensed physicians, but can only practice while holding a position with the medical school and cannot practice outside of the institution. The Board issued its first permit in 1999.

SB 59 (Perata, Chapter 539, Statutes of 1999), requires Healthcare Service Plans to designate a medical director who must be a California-licensed physician. The Board notified all of the Healthcare Service Plans of this requirement, and they are in compliance.

AB 1820 (Wright, Chapter 440, Statutes of 2000) Geriatric Medicine and Continuing Education, requires all applicants, after January 1, 2004, complete course work in geriatric medicine in medical school or in postgraduate training. General internists and family physicians, who have a

patient population of which 25% or more are 65 or older, must complete at least 20% of all mandatory CE in the field of geriatric medicine or the care of older patients. To provide physicians with ample time to complete this new requirement, the Board will begin to audit compliance in 2003.

Enforcement:

AB 563 (Prenter, Chapter 514, Statutes of 1997), grants the Board the authority to automatically suspend a medical license if the physicians license from another state was suspended or revoked. The suspension is for the duration of the suspension/revocation or until an alternate ruling is rendered as a result of an administrative hearing action in California. Physicians who maintain their primary practice in California are not affected by the immediate suspension provisions of the law, but are subject to independent investigation. This law protects consumers by keeping physicians who have caused public harm in another state from moving to California and setting up a practice before a hearing can be held. The Board implemented this provision in January 1998.

AB 2387 (Baugh, Chapter 892, Statutes of 1998), prohibits Medi-Cal reimbursement for certain invasive medical procedures rendered by a physician who is on probation with the Medical Board. The Medical Board, as well as the Dental and Osteopathic Boards, must report to the Legislature annually on the number of licensees placed on probation during the previous year who are not receiving Medi-Cal reimbursement, and those placed on probation who are receiving reimbursement for certain surgical and invasive procedures as a result of a determination of compelling circumstances. This codified Budget Act requirements, a process the Board implemented in fiscal year ending 1998. In its February 2001 report to the Legislature, 21 physicians were reported on probation for invasive procedures.

AB 2719 (Gallegos, Chapter 301, urgency statutes B immediately effective on August 17, 1998, Statutes of 1998), created a statute of limitations for filing disciplinary action against a doctor. The law now requires accusations against physicians to be filed within three years after the Board discovers the act or omission alleged as the grounds for disciplinary action, or within seven years after the act occurred, whichever is first.

AB 2571 (Campbell, Chapter 269, Statutes of 2000) Statute of Limitations Exemption, created an exception to the three year/seven year

statute of limitations created by AB 2719 (Gallegos), allowing the Board to file an Accusation without regard to year of the occurrence or discovery if there is proof that the doctor intentionally concealed the incompetent or negligent acts from discovery.

SB 1828 (Speier, Chapter 681, Statutes of 2000) Prescribing On-Line without A Good Faith Prior Examination, provided a penalty of a \$25,000 fine, per occurrence, for those who prescribe drugs over the Internet without prior examination.

The Boards Diversion Program:

AB 1974 (Friedman, B., Chapter 644, Statutes of 1996), requires peer review bodies to report to the Medical Boards Diversion Program within 15 days of initiating an investigation of a physician suffering from mental or physical illness sufficient to impair his or her ability to practice medicine safely.

The Diversion Program must monitor the progress of a peer review body's investigation, and report to the Medical Boards chief of enforcement if it is determined that the progress of the investigation is not adequate to protect the public. Requires the Medical Board to investigate the basis of all peer review actions taken within 30 days of notification, to determine if a temporary restraining order or interim suspension order is necessary for public protection.

Pain Management and Education:

SB 402 (Green, Chapter 839, Statutes of 1997), established the APain Patients Bill of Rights. Physicians may refuse to prescribe opioid medication for patients who request the treatment for severe chronic intractable pain, however, they must inform the patient that other physicians specialize in the treatment of such pain with methods that include the use of opiates. The Board continuously informs its licensed physicians through the AAction Report on policies and issues related to pain management, the latest information was published in the July 2001 issue.

AB 2305 (Runner, Chapter 984, Statutes of 1998), provides that physicians who are in compliance with the California Intractable Pain Act will not be subject to disciplinary action. Medical experts reviewers retained for an investigation of complaints relative to prescribing for pain must be specialists in pain management. Healthcare service plans must approve or

deny coverage for terminally ill enrollees within 72 hours of receipt of the information. The Board continuously informs its licensed physicians through the AAction Report@ on policies and issues related to pain management, the latest information was published in the July 2001 issue.

AB 2693 (Migden, Chapter 789, Statutes of 1998), allows prescriptions for Schedule II controlled substances used by terminally ill patients are exempt from the use of a triplicate form. Prescriptions falling under this exemption must contain the phrase A1159.2 exemption.@ The Board continuously informs its licensed physicians through the AAction Report@ on policies and issues related to pain management, the latest information was published in the July 2001 issue, which specifically addressed this legislation.

SB 1140 (Committee on Health and Human Services, Chapter 791, Statutes of 1998), requires the Medical Board and the Board of Registered Nursing to consider including a course on pain management in their continuing education requirements. The Medical Board must periodically develop and disseminate information and educational material regarding pain management techniques and procedures to each licensed physician and surgeon and to each general acute care hospital, and must consult with the Department of Health Services in developing materials to be distributed.

AB 791 (Thomson, Chapter 403, Statutes of 1999), added pain management and end-of-life care to the curriculum requirements for students entering medical school on or after June 1, 2000. The Board notified medical schools of this requirement in 1999.

AB 2018 (Thomson, Chapter 1092, Statutes of 2000) Triplicate Prescription Program, allows physicians to request, during a 30-day period, a sufficient supply of triplicate prescription forms to meet the needs of their patient population. Physicians or employees may complete the form, providing the physician signs it. Pharmacists are allowed to notify the prescriber of an unintended error on the form and obtain approval for correction, so the patient does not have to return to the office for a corrected prescription, as long as a corrected copy is sent or faxed from the physician to the pharmacist within seven days. Licensed physicians were notified in the January 2001 AAction Report@ and will publish follow-up articles in future issues.

Outpatient and Cosmetic Surgery:

Because of the continually evolving environment in which more surgeries are performed in outpatient settings, and because of the high visibility of many of these (especially cosmetic surgery), the Board formed a Committee on Plastic and Cosmetic Surgery to identify methods in which to improve patient safety.

This Committee solicited testimony from a number of parties, including malpractice insurers, accreditation agencies, specialty societies, specialty boards, and consumer representatives. In summary, there were a number of concerns raised that were appropriately remedied through legislation. A major problem identified was a lack of objective data in order to make decisions on evidence, rather than anecdotal data. In addition, it appeared that false advertising was prevalent in the cosmetic surgery marketplace, and there were insufficient safeguards in outpatient settings. To address these problems, three bills were passed:

AB 271 (Gallegos, Chapter 944, Statutes of 1999):

The most significant elements contained in this bill are:

- § Requires Atwo staff persons on the premises, one of whom shall either be a licensed physician and surgeon or a licensed healthcare professional with current certification in advanced cardiac life support, as long as a patient is present who has not been discharged from supervised care.@
- § Requires physicians doing outpatient surgery to have liability insurance or participate in an interindemnity trust.
- § Requires surgeons who perform a scheduled medical procedure in an outpatient setting to report within 15 days any deaths or any transfers to a hospital that requires a stay of over 24 hours. After January 1, 2002, these reports will be required to be sent to the Office of Statewide Health Planning and Development (OSHDP), rather than the Medical Board.
- § Amended 1248.15 of the H&S Code, which requires that the Board adopt standards for accreditation. It amended that section to require that one of the two staff persons must be currently certified in advanced cardiac life support (ACLS). (Effective July 1, 2000.)

Since this law went into effect, regulations have been adopted to implement the reporting element of the law, as well as setting the Aadequate@ amount of malpractice insurance at \$1 million per incident/\$3 million per year. A statistical summary of reported deaths and hospital transfers was published in the July 2001 AAction Report.@

SB 836 (Figueroa, Chapter 856, Statutes of 1999), made the advertising law (B&P Code 651) more specific by effecting the following changes and clarifications to the statute:

- § Pictures and images must accurately depict results of the procedures being advertised and prohibits alteration.
- § Prohibits the use of pictures of models without clearly stating that the person 's a model.
- § Requires that ads using ABefore and After@ pictures specifically state what procedures were actually performed.
- § Requires that claims made be substantiated scientifically or objectively.
- § Scientific claims must be supported by reliable, peer reviewed, published scientific studies.
- § Testimonials must be substantiated.

While no regulations were required to implement these amendments in the law, it has provided the Boards enforcement staff a clarified law in order to identify and take action for misleading, and thus illegal, marketing practices.

SB 450 (Speier, Chapter 631, Statutes of 1999), dealt with two items that were addressed by the Plastic and Cosmetic Surgery Committee:.

1) Advertising:

- § Requires physicians advertising board certification to include the name of the certifying board in the ad.
- § Adds Aimage@ to advertising prohibitions C the law used to read Aclaim or statement,@ now it also includes images.
- § Adds Internet Communications to the law, and makes clear that it is advertising as well, and not confined to print, radio, and TV.

2) Liposuction:

The bill requires that the Board adopt extraction and postoperative care standards for liposuction. The bill states:

The Medical Board of California shall adopt extraction and postoperative care standards in regard to body liposuction procedures performed by a physician and surgeon outside of a general acute care hospital, as defined in Section 1250 of the Health and Safety Code. In adopting those regulations, the Medical Board of California shall take into account the most current clinical and

scientific information available. A violation of those extraction and postoperative care standards constitutes unprofessional conduct.

The advertising elements of this bill have been helpful to our enforcement staff and have closed one of the loopholes to the law relating to advertising board certification. In the past, a board-certified gynecologist or psychiatrist could advertise that they were board certified, while advertising for cosmetic procedures, implying certification in cosmetic procedures. Doctors must now include the name of the certifying board.

As for the mandate to set liposuction extraction and post-operative care standards, the Committee continues to meet and take testimony in order to identify a practical means to fulfill the law, and regulations will be promulgated in the Division of Medical Quality.

Allied Healthcare Professions and Alternative Medicine:

SB 1479 (Figueroa, Chapter 303, Statutes of 2000) Midwifery Practices Act, increased the requirements for informed consent that licensed midwives must provide to clients. An informed consent form must be signed by both the midwife and client and a copy must be placed in the medical record. In addition, midwives are allowed to register the birth. The Board has scheduled a committee meeting in September 2001 to review these requirements and discuss possible regulatory language with interested parties.

SB 2100 (Vasconcellos, Chapter 660, Statutes of 2000) Alternative Medical Practices and Treatment, set forth legislative intent and added an Article entitled AAlternative Practices and Treatment.@ The intent language asks for a review by the Medical Board and Osteopathic Medical Board into the emergence of holistic health and whether the boards should redesign their systems of operation to meet the healthcare needs of individuals seeking emerging modalities of healthcare. It requires the Medical Board, on or before.

July 1, 2002, to establish disciplinary policies and procedures to reflect emerging and innovative medical practices, solicit participation of interested parties, and consult with technical advisors as necessary. Specifically the Board is directed to assess standards for informed consent and investigations. The University of California is requested to review cancer treatments and therapies for the purpose of assisting the Governor and Legislature in assuring that California consumers diagnosed with cancer have the best range of treatment and therapeutic choices.

To comply with the mandates to work with interested parties on issues of holistic health and how the Board systems should address them, as well as enforcement and disciplinary policies relating to alternative and complementary medicine, the Board established a Committee on Alternative Medicine. (For more detailed information, see Part II, ADealing with Alternative Medicine@ on page 83.)

Access to Medical Care for a Diverse Population:

AB 2394 (Firebaugh, Chapter 802) Cultural and Linguistic Competency, established a Task Force on Culturally and Linguistically Competent Physicians and Dentists and a subcommittee to evaluate a pilot program for physicians and dentists from foreign countries to practice in California. The Task Force is chaired jointly by the directors of the Department of Consumer Affairs and the Department of Health Services. The Executive Director of the Medical Board is a member of this task force along with others specified in the law or appointed by the Task Force chairs. It must develop recommendations for continuing education programs that include language proficiency standards, identify key cultural elements necessary to meet cultural competency, assess the need for voluntary certification standards, hold hearings and meetings to obtain input from ethnic minority groups, and report its findings to the Legislature by January 1, 2003. A subcommittee is established to examine the feasibility of establishing a pilot program that would allow Mexican and Caribbean physicians and dentists to practice in nonprofit community health centers in California's medically underserved areas. This subcommittee, chaired by the director of DHS, has at least seven members including the Executive Director of the Medical Board. This subcommittee reported its findings to the Task Force which is charged with forwarding a report and any additional comments to the Legislature. The Medical and Dental Boards are required to pay for the administrative costs of this bill.

SB 450 (Speier, Chapter 631, Statutes of 1999), created a waiver of physician licensing renewal fees for physicians who entirely dedicate their practice to volunteer, unpaid service to the needy, in addition to addressing the issue of advertising and liposuction extraction standards. (See ALegislative Changes; Outpatient and Cosmetic Surgery,@ SB 450 on page 21.)

Organizational and Operational Changes to the Board

Since the last Sunset Review, the Medical Board has made a number of organizational and operational changes to the Board to address the challenges and issues of an ever and always changing medical profession. Some of those changes include:

Office of the Medical Director:

In July of 2000, the Board established the Office of the Medical Director. As the purpose of the Medical Board is to improve the quality and safety of healthcare through the promotion and enforcement of high standards for licensing and medical practice, the office was created to support these functions and to develop programs and policies consistent with the Boards mandated responsibilities. Specifically, the Director, who is a licensed physician, assists the Board and its staff in policy and program development by accessing and applying scientific information, serves as a liaison to healthcare constituencies, and works with the constituencies to define issues of importance through planning, research, policy and legislative development. Of most importance to the Medical Board, is the ability of a Medical Director to work to promote preventative initiatives and studies that can improve the quality of care by preventing medical error. Just as in medicine, prevention of harm is preferable to treatment after succumbing to its effects.

Operation Safe Medicine:

Over the years, the Medical Board Enforcement staff has witnessed an increase in fraudulent practice in depressed socioeconomic populations. There has been a growing phenomena of the spread of unlicensed, unregulated Aclinics,@ predominately in Southern California.

These clinics usually provide various medical treatments by an unlicensed individual. Frequently, the consultation results in the dispensing of a dangerous drug which may not be manufactured under FDA guidelines or even approved for use in the United States. In increasing numbers, the results of these practices have been untreated disease, health complications, and death.

These clinics have grown as Californias immigrant population has grown. They are almost always located in areas with large immigrant populations where healthcare coverage is scarce. The problem of a lack of healthcare for indigent populations is well-documented, and as this situation persists or even grows, an increase in these substandard operations can be expected. (See AEmerging Issues and Trends, AProviding Care to the Underserved,@on page 84.) Unfortunately, the lack of qualifications of the practitioners means that this care is often quite dangerous. In the past years, there have been a number of highly publicized deaths

of toddlers who were treated at such clinics, as well as deaths reported by emergency room workers. Doctors in those communities are reporting an increase in dangerous reactions from faulty diagnoses made in these illegal clinics.

In the past, the Board has found some success in combating these kinds of operations through special strike forces comprised of personnel from the Medical Board and local law enforcement. Unfortunately, not all jurisdictions have the resources to sustain this type of activity. For that reason, the Medical Board, as it is the agency with the statutory responsibility to protect consumers from unsafe medical practices, established AOperation Safe Medicine.@"

In fiscal year ending 2001, the Department of Finance granted the Board ' s request to establish four dedicated investigators to work exclusively on these unlicensed practice_issues. Operation Safe Medicine began operation in January 2001, and has already produced some significant results.

Since its recent creation, there have been two notable cases that have resulted in the filing of felony criminal charges. The first involved an unlicensed person treating a seven-year-old, claiming that she could cure the child of bone cancer through vitamins and minerals, and could monitor the childs progress through examination of the childs eyes. The parents were told that they could cease the childs chemotherapy, which delayed the treatment for two months. The parents returned to the hospital after they noticed swelling of their childs leg, as well as a limp and the experience of pain. The child has since resumed chemotherapy, although one cannot assess the damage the two-month delay in treatment may have caused.

The second notable case involved an unlicensed person treating a 13-year-old child for unexplained weight loss. The practitioner diagnosed worms, anemia, and low blood count, and the treatment rendered was body massage, evaluating arm strength, and prescribing of dietary supplements. The child, it appears, was actually suffering from anorexia nervosa. The practitioner was convicted of felony unlicensed practice of medicine, and is awaiting sentencing.

Internet Crimes Specialist:

Over the past several years, crimes on the Internet have grown proportionally with the growth of the Internet and Internet commerce. Violations of the law have ranged from misleading advertising on Web sites to trafficking in narcotics. As a law enforcement agency that is charged with enforcing the laws surrounding medical practice, the Board knew it would need to dedicate resources to address this unique form of crime.

In 2001, the Board dedicated one position to Internet crimes by creating an Internet Crimes Specialist. It is the job of this specialist to monitor computer activities and media generated to detect violations and gather evidence. This specialist assists investigators when needed with technological expertise, using investigative techniques utilizing computer technology and theory, as well as being responsible for conducting investigations and initiating prosecutions within the Board ' s administrative system. As Internet crime often involves a number of state, Federal, and local jurisdictions, this specialist often must work with other law enforcement agencies and prosecutors.

There are a number of violations of law already being observed. There are Internet sites involved in the treatment of illnesses and the prescribing of drugs without any examination, which specifically violates California prescribing law. Unfair, misleading, and fraudulent advertising of physician services are also being observed and some Internet sites make outrageous and unscientific claims about procedures or remedies. Some services offered are the practice of medicine, and those rendering the service are not licensed. The Internet Crimes Specialist will address these violations through present enforcement remedies, and will work with other appropriate jurisdictions and law enforcement agencies to ensure appropriate action is taken.

Cooperation and Coordination with Other Law Enforcement Agencies:

To further increase productivity and avoid duplication of efforts, the Boards enforcement staff has been working with other law enforcement agencies to address shared mandates and generally promote better public protection. The Board has been working with the Attorney Generals Office, the Department of Insurances Fraud Bureau, the Department of Health Services Medical Care Service Division, and the Department of Justices Bureau of Medi-Cal Fraud on issues involving MediCal, Medicare, and insurance fraud to develop a dialogue to explore ways in which our agencies can work together. The Board has also provided medical expertise to the Attorney Generals Offices Bureau of Elder Abuse, as well as the Department of Managed Healthcare to assist them with evaluating issues of appropriate care and medical treatment.

Expansion of the Medical Expert Program:

At the last Sunset Review Hearing, the Board reported that it had created the Expert Reviewer Program, composed of medical experts available to review complaints, assess clinical competence, and assist in the determination of whether a specific practice was within or outside the community standard of care. The program now includes approximately 750 physicians from a broad range of specialties. Minimum requirements to be an expert reviewer include: current board

certification, active clinical practice, and at least five years of clinical experience. The Board continues active recruitment for the Expert Reviewer Program to ensure that medical experts are available to address all types of contemporary medical practice. This scope includes new and rapidly evolving areas including pain management and complementary and alternative medicine.

MAJOR STUDIES OF THE BOARD

The underlying goals of the Medical Board are to improve the quality and safety of healthcare through the promotion and enforcement of high standards for licensing and medical practice. To advance these aims, the Board appointed a medical director in September 2000. One of the main functions of the medical director is to plan and conduct special projects and studies that can support the development of sound health policy regarding medical practice. Several of these projects and studies are outlined below.

Practitioner Remediation to Enhance Patient Safety (PREPS) Project:

The Institute of Medicine (IOM) report, *To Err is Human*¹, brought dramatic attention to the issue of patient safety with the assertion that up to 98,000 Americans die each year from preventable medical errors in hospitals. As part of the recommendations to address this major public health problem, the report challenged health professional licensing bodies to, AYwork with certifying and credentialing organizations to develop more effective methods to identify unsafe providers and take action.@ While researchers in patient safety emphasize the importance of a system approach to reducing medical errors, the IOM report acknowledged that, AYsome individuals may be incompetent, impaired, uncaring, or may even have criminal intent.@ Thus, there appears to be a need to address the fact that there is a subset of physicians that have knowledge or skills deficits that could contribute directly or indirectly to the occurrence of medical errors and adverse patient outcomes.

In recognition of the above need, the Citizen Advocacy Center (CAC), with funding from the Health Resources and Services Administration (HRSA), has proposed the creation of a number of pilot projects around the country. These projects would establish demonstration systems that could identify practitioners in need of remedial training and direct them to effective providers of such training and education. In these CAC pilots, a medical board would partner with one or more hospitals with both the board and hospital being responsible to identify candidates for remedial training. Appropriate candidates would then participate in a remediation plan acceptable to both the hospital and board. The ultimate goal of the CAC program is to improve patient safety and the quality of care through this directed education and training. The CAC is a not-for-profit, training, research,

and support network for public members of healthcare regulatory and governing boards.

At the November 2000 meeting of the Medical Board, the Board approved the proposal to proceed with an examination of the feasibility of conducting a pilot project in California similar to that proposed by the CAC. Among participants who have been convened to discuss this concept, there has been a consensus to support launching a CAC pilot project in California. The working title for this California project is the APractitioner Remediation to Enhance Patient Safety (PREPS) Project. Planning for this complex project will proceed through 2001.

Medical School Professionalism Problems as a Risk Factor for Physician Discipline:

For several months, Board staff have been working with medical educators at the University of California, San Francisco (UCSF) on an applied research project. The associate dean for student affairs has studied, written about, and dealt with medical student professionalism. The serious nature of some of these issues has led her to hypothesize that professionalism problems in medical school could be a risk factor for subsequent discipline by the Medical Board. The Board is working with UCSF on a case-control study to test this hypothesis. The study includes examination of records of serious discipline in UCSF medical school graduates in the period of 1991-2001. Information on cases of serious discipline is public by law. Medical school professionalism will be assessed by student performance records retained by the University. Controls will be matched by year of graduation, gender, and medical specialty. Approval for the project has been obtained through the University's human subjects research committee. Because of the professional ties among UCSF staff and counterparts at other California medical schools, the study may be able to be enlarged to include several other institutions.

The larger role of this study is to improve our understanding of the risk factors for physician discipline so that preventive interventions can be designed to manage modifiable risk factors prior to the occurrence of patient harm or the violation of law.

The Strategic Alliance for Error Reduction (SAFER) in California Healthcare:

Recently, the five University of California (UC) medical campuses submitted a joint application to the Agency for Healthcare Research and Quality (AHRQ) to develop a research and evaluation center in patient safety. In developing the grant application, the principal investigator consulted with the Medical Board, along

with a number of other licensing bodies and external stakeholders. While the initial focus of SAFER is to develop patient safety models for use in the medical centers of UC, the broader goal of the project is to disseminate effective provider and patient education programs throughout the state with the involvement of a range of project partners.

The Medical Director will continue to serve as an adviser to SAFER and will be exploring how the effective interventions that are developed from the project can be translated widely into practice around the state. In addition to developing safety-related patient and provider education, the project will be studying how information technology can be used to support reduction of medical errors in large medical centers.

Risk Factors for Physician Discipline:

There are few published studies of the epidemiology of disciplined physicians.² Yet, the need for evidence to develop sound and equitable medical policy continues to grow. Issues such as the prevention of medical errors, development of post-licensure assessment models, expansion of post-graduate training requirements and enhancement of medical quality overall can be addressed most effectively with an increased understanding of the descriptive epidemiology of disciplined physicians and the risk factors leading to discipline.

The Office of the Medical Director is conducting, with technical assistance from UCSF, a case-control study to examine age, years in practice, years of postgraduate training, board certification, gender, specialty, and location of training (domestic vs. international), as potential predictors of physician discipline in California.

Cases will be selected from all completed Board actions resulting in discipline during a multi-year period. Approximately 1,000 cases will be identified. Controls will be identified from the general population of California-licensed physicians. Characteristics of cases and controls such as years of training, specialty, and board certification will be obtained from the American Medical Associations *Directory of Physicians in the United States*.

Multivariate statistical techniques, such as multiple logistic regression, will be used to identify risk factors for discipline. This study will build upon previous work by using a significantly larger sample size that will enable the examination of additional, potential predictors of discipline with a particular recognition of postgraduate training.

References

- ¹Kohn LT, et al., eds. *To Err is Human*. Washington, D.C.: National Academy Press; 2000.
- ²Morrison J and Wickersham P. Physicians disciplined by a state medical board. *JAMA*. 1998;279:1889-1893.
- Schlesselman JJ. *Case-Control Studies: Design, Conduct, Analysis*. New York, NY: Oxford University Press; 1982.

BUDGET & STAFF

The Medical Board operates on an annual budget of approximately \$36 million, with about 70% of its budget devoted to enforcement activities. The Board is funded primarily through licensing fees, with 85% coming from license renewals, 5% from first-time licenses, 6% from application fees, and the remaining 4% from various less significant sources, such as delinquent fees, penalties, fines, and cost recovery. It has a staff of almost 300 employees, over half of which serve entirely in the Enforcement Program.

A significant portion of expenditures, over 20%, are paid to other agencies for services needed within the disciplinary structure, such as the Office of the Attorney General for prosecuting attorneys and the Office of Administrative Law for hearing officers. In addition, over 10% of the Boards revenue is paid to the Department of Consumer Affairs for such services as information technology and administrative services.

The Boards licensing program is entirely self-supported through licensing application fees. Applicants fees cover the costs of processing and providing certificates. The Boards enforcement activities are paid by license renewal fees and other sources, such as fines or cost recovery ordered through the disciplinary penalty process.

As with all fee-supported agencies, budgeting can be problematic and challenging. Since its last review, the Board has experienced a significant rise in costs without an equal rise in revenue. Rents have increased approximately 27% due to expansions and increases in square footage costs, personnel costs have increased about 13%, as well as a need for increased staffing to address increased workload. Increases in travel expenses, required for the maintenance of a field enforcement

function, have also had a significant impact on expenditures. In addition, the price for services performed by other State agencies has risen, such as fees for attorney services by the Attorney Generals Office. (From \$98 per hour to \$112.)

The price of technology has had its impact as well. Communications costs have risen 17%, and the maintenance of information technology services have continued to rise with the prospect of even greater costs looming as the Board works with the Department of Consumer Affairs to identify replacements for the obsolete computer tracking systems for complaints, investigations, and application processing C the Legacy, CAS, and ATS Systems.

In the effort to meet statutory mandates, as well as provide better information to consumers, personnel was redirected and costs were incurred to improve and expand the Boards Web site, and provide publications to the consumer and the profession. Printing costs have risen 44% as well as postage and increased distribution costs.

The future promises to hold similar challenges. In addition to expecting routine personnel, equipment, and building costs to rise, it is expected the Board will face a number of large expenditures for several programs and services, particularly those relating to technology. The Boards current main-frame computer system, which houses all of the licensing and disciplinary data for physicians, is obsolete, and the Department of Consumer Affairs (DCA), the agency responsible for this system, is working to upgrade it to a more useful and stable system. Future costs to the Board in excess of \$1 million for development are not beyond reason. Telecommunication technology and Web site development, especially as the State moves forward with e-government initiatives, certainly will greatly impact expenditures in the future.

The Medical Board is like any other fee-supported agency in that its revenues are relatively static while costs can fluctuate over short periods of time driven by workload, legislative mandate, inflation or one-time events that require commitment of funds. The Board seeks to moderate the potential for fiscal uncertainty and crisis that these forces can cause by closely monitoring its fund condition. Years of experience with license trends allows for fairly accurate estimates of the anticipated revenue that will be available to fund program operations. Furthermore, the Board aggressively seeks opportunities to limit its expenditures by the close monitoring of each of its current cost centers. Finally, the Medical Board has consistently sought to align responsibility for funding services with those who are responsible for the costs. This is reflected by the direct assessments found, for example, in the Diversion Program, investigative cost recovery, probation monitoring and application for specialty board designation, to name a few.

Revenue & Expenditure History:

REVENUE Dollars in Thousands:	ACTUAL				PROJECTED	
	97/98	98/99	99/00	00/01	01/02	02/03
Licensing Fees*	32,496	32,965	32,288	32,313	32,344	32,329
Fines & Penalties**	276	296	274	280	285	285
Other	470	509	456	838	469	475
Interest	325	507	840	1,153	946	771
Totals	33,567	34,277	33,858	34,584	34,044	33,860

*Includes renewal, application, examination and initial licensing fees

** Includes citations, delinquent fees and penalty fees.

EXPENDITURES Dollars in Millions	ACTUAL				PROJECTED	
	97/98	98/99	99/00	00/01	01/02	02/03
Personnel Services	15.0	15.2	15.4	17.0	18.0	18.0
Operating Expenses	17.8	18.1	18.3	19.7	19.9	19.9
(-) reimbursements	(1.5)	(1.6)	(2.0)	(2.0)	(2.0)	(2.0)
(-) Distributed Costs	(0.8)	(0.8)	(0.7)	(0.7)	(0.7)	(0.7)
Totals	30.5	30.9	31.0	34.0	35.2	35.2

EXPENDITURES BY PROGRAM COMPONENTS Dollars in Millions	97/98	98/99	99/00	00/01	Average % Spent by Program
Enforcement/Probation	21.8	22.0	22.2	24.4	71.5%
Examination	1.0	1.1	0.0	0.0	1.7%
Licensing	2.8	2.7	2.6	2.8	8.6%

Administrative	4.1	4.3	5.4	5.8	15.5%
Diversion	.8	.8	.8	1.0	2.7%
Totals	30.5	30.9	31.0	34.0	

ANALYSIS OF FUND CONDITION (Dollars in Millions)	99/00	00/01	01/02	02/03 (Projected)	03/04 (Projected)	04/05 (Projected)
Total Reserves, July 1	11.5	14.4	15.0	12.2	9.3	6.2
Total Rev. & Transfers	33.9	34.6	34.0	33.9	33.7	33.5
Total Resources	45.4	49.0	49.0	46.1	43.0	39.7
Total Expenditures	31.0	34.0	36.8*	36.8*	36.8*	36.8*
Reserve, June 30	14.4	15.0	12.2	9.3	6.2	2.9
Months in Reserve	5.1	4.9	4.0	3.0	2.0	.9

*Unscheduled reimbursements not reflected

Current Fee Schedule and Range:

Fee Schedule: Physician & Surgeon	Current Fee	Statutory Limit
Application Fee	\$442	none
Admin. Fee	n/a	n/a
Exam Fee	n/a	n/a
Original License Fee	\$600 \$300 for residents-in-training	\$600 \$300 for residents-in-training
Renewal Fee	\$600 Biennially	\$600 Biennially
Fee Schedule: Registered Dispensing Optician Firm	Current Fee	Statutory Limit
Application Fee	\$75	\$100
Admin. Fee	n/a	n/a
Exam Fee	n/a	n/a
Original License Fee	n/a	n/a
Renewal Fee	\$75	\$100
Fee Schedule: Contact Lens Dispenser	Current Fee	Statutory Limit

Application Fee	\$75	\$100
Admin. Fee	n/a	n/a
Exam Fee	n/a	n/a
Original License Fee	n/a	n/a
Renewal Fee	\$75	\$100

Fee Schedule: Spectacle Lens Dispenser	Current Fee	Statutory Limit
Application Fee	\$75	\$100
Admin. Fee	n/a	n/a
Exam Fee	n/a	n/a
Original License Fee	n/a	n/a
Renewal Fee	\$75	\$100
Fee Schedule: Contact Lens Dispenser	Current Fee	Statutory Limit
Application Fee	\$75	\$100
Admin. Fee	n/a	n/a
Exam Fee	n/a	n/a
Original License Fee	n/a	n/a
Renewal Fee	\$75	\$100
Fee Schedule: Research Psychoanalyst	Current Fee	Statutory Limit
Application Fee	\$100	\$100
Admin. Fee	n/a	n/a
Exam Fee	n/a	n/a
Original License Fee	n/a	n/a
Renewal Fee	\$50	\$50
Fee Schedule: Licensed Midwife	Current Fee	Statutory Limit
Application Fee	\$300	\$300
Admin. Fee	n/a	n/a
Exam Fee	n/a	n/a
Original License Fee	n/a	n/a
Renewal Fee	\$200	\$200

Fee Schedule: Fictitious Name Permit	Current Fee	Statutory Limit
Application Fee	\$50	\$50
Admin. Fee	n/a	n/a
Exam Fee	n/a	n/a
Original License Fee	n/a	n/a
Renewal Fee	\$40	\$40

Fee Schedule: Outpatient Surgery Accreditation Agencies	Current Fee	Statutory Limit
Application Fee	\$5,000	\$5,000
Admin. Fee	n/a	n/a
Exam Fee	n/a	n/a
Original License Fee	n/a	n/a
Renewal Fee	\$100 per accredited setting, for a three-year period.	\$100 per accredited setting, for a three-year period.
Fee Schedule: Specialty Boards	Current Fee	Statutory Limit
Application Fee	\$4,030	Processing costs
Admin. Fee	n/a	n/a
Exam Fee	n/a	n/a
Original License Fee	n/a	n/a
Renewal Fee	none	none

Please see Organizational Chart, Appendices V.

LICENSURE REQUIREMENTS

Licensure Requirements for Physicians & Surgeons:

Education and Experience

The process of becoming a licensed physician and surgeon in California involves rigorous standards befitting the important impact the profession has on all Californians. These standards are set forth in laws and regulations and are continually being refined through the statutory and regulatory processes to ensure that only qualified practitioners are licensed to serve healthcare consumers. The requirements for licensure are not confined to verifying education and training, but

also require each applicant to meet standards of personal fitness that are substantially related to the practice of medicine.

Requirements

The education and testing requirements each applicant must meet to be licensed as a California physician and surgeon are set in statute and vary, depending upon the background of the applicant; they are generally described in terms of the "pathway" to licensure. There are five pathways set forth in statute, each delineating specific requirements an applicant must meet to be licensed. Requirements of the pathways that are defined in statute are shown in Licensing Pathways Chart, Appendices III.

Educational requirements may be summarized as follows:

- § Two years of pre-professional, post-secondary education
- § 32 months of medical curriculum instruction including 72 weeks of clinical instruction as required in B&P Code Sections 2089 and 2089.5
- § A diploma or certificate of completion of all formal requirements for graduation from medical school.

Graduates of medical schools not accredited by the Liaison Committee on Medical Education or the Coordinating Council on Medical Education of the Canadian Medical Association (Section 1314 CCR) are required to be certified by the Educational Commission for Foreign Medical Graduates (ECFMG).

Postgraduate Training

Physicians receive their postgraduate training in programs, known as residency programs, accredited by the Accreditation Council for Graduate Medical Education (ACGME). One year of postgraduate training in an approved postgraduate training program is required for domestic graduates, two years for international graduates.

The individual ultimately responsible for the training provided by the residency program is the program director, who is a licensed physician and generally the chairperson of a medical department such as cardiology, anesthesiology, gynecology/obstetrics, etc. Residents may be under the supervision of a number of licensed physicians for different rotations and shifts, but they all report to the program director. ACGME accreditation requires that residents be paid for their services and program participation. Physicians supervising residents are not registered as supervisors with the Board, but prior to beginning training, each resident must submit a registration form to the Board. This form includes information about the facility and the identity of the program director.

The first year of the postgraduate training requirement must currently be satisfied by completion of twelve continuous months of training in an approved program in the United States or Canada that includes at least four months of general medicine. Approved programs in any of the following specialties may satisfy the general medicine requirement:

- \$ Family practice
- \$ Internal medicine
- \$ Surgery
- \$ Pediatrics, or
- \$ Obstetrics and gynecology

International graduates must complete a second year of postgraduate training in order to qualify for licensure. Most U.S. postgraduate residency programs are three years long, so this requirement is not difficult to meet.

Strengthening Current Requirements

Over the years, requirements for physician licensure have been amended. The current standards reflect national trends for medical education, and it is expected that future changes will continue to be driven by national trends. Postgraduate training for prospective physicians is one area where the Board has proposed strengthening standards. California currently requires one year of postgraduate education for domestic graduates and two years for international graduates to qualify for licensure. Nationally, there is some variability with many states requiring two or three years for graduates of non-U.S. or Canadian medical schools, and some requiring two or three years for U.S. and Canadian graduates. With the increasing complexity of medical science, the Federation of State Medical Boards (FSMB) has adopted a position that full and unrestricted licensure should be delayed until after the completion of the third year of postgraduate training and urges all states to adopt this higher standard. The Medical Board of California is currently engaged in a study designed to determine if there are statistically valid measurements that would indicate the appropriate length of training to be required. The Division of Licensing will address the issue upon completion of the study.

Verification of Information Provided by Applicants

The application form for a physician and surgeon license includes several questions that require the applicant to disclose licensure in other states, disciplinary action, malpractice judgments over \$30,000, suspension or termination of practice privileges, program dismissal, conditions of impairment, and criminal convictions. In the course of processing the application, every effort is made to ensure accuracy of the information supplied by each applicant. Medical degrees of domestic graduates are confirmed by either a diploma copy certified by the medical school,

or an official transcript mailed directly to the Board by the medical school showing that the degree was granted. Graduates of international schools are required to submit an original diploma for inspection and degree verification. Documentation of clerkships and postgraduate training is submitted on board forms completed and certified by training directors; they must bear an original signature and seal and are signed under penalty of perjury. Fingerprints for each applicant are submitted to the California Department of Justice and the Federal Bureau of Investigation for clearance or criminal history disclosure.

Independent sources are also used; records of the American Medical Association (AMA) database are checked to verify licensure in other states; checks of the FSMB Action Databank and National Practitioner Data Bank may help determine if there has been disciplinary action or suspension of practice in another jurisdiction. Additionally, a certification letter is required from every state licensing board where the applicant is or has been licensed. These letters provide a history of any disciplinary actions or practice restrictions that may have taken place. Information and documentation received directly from postgraduate training program directors also provide insights into previous performance or disciplinary problems during training that need further exploration with the applicant. With rare exceptions, no license is issued without a report from the AMA and at least one fingerprint clearance. If one of these information source checks reveals misconduct that the applicant failed to mention on the application, he or she is asked to provide a detailed narrative statement of explanation and all pertinent information.

Examinations

A quality examination is a key component of assuring the competency of physicians applying for licensure in California. Over the years, the Board has used several different examinations as the national trend has evolved. The United States Medical Licensing Examination (USMLE) was adopted as the standard examination in 1993 and was first administered in 1994. All applicants for physician and surgeon licensure in California are required to have passed Steps 1, 2 and 3 of the USMLE or an equivalent written examination. The examinations accepted are as follows:

- § Steps 1, 2 and 3 of the United States Medical Licensing Examination (USMLE)
- § All three parts of the National Board of Medical Examiners (NBME) exam (last administered in 1993)
- § A state medical board licensing examination taken prior to June 1969
- § Components 1 and 2 of the Federation of State Medical Board's Licensing Examination (FLEX) (last administered in 1995)
- § All parts of the Licentiate of the Medical Council of Canada (LMCC)

written examination, or

- § Various combinations of the FLEX, NBME, and USMLE are also acceptable to satisfy the written examination requirement.

Additionally, to participate in postgraduate training in the United States, graduates of international medical schools must be certified by the ECFMG. To obtain this certificate, they must:

- § Pass steps 1 and 2 of the USMLE, or
- § Have passing scores on one of many acceptable combinations of the USMLE, NBME, for FLEX exams, and
- § Pass an English language exam.

The computerized Special Purpose Examination (SPEX) is required for the following individuals:

- § Graduates of international medical schools who have practiced medicine with an unrestricted license in another state for four or more years, and
- § Those who have served as an active member of the military or another federal program for four or more years.

Formerly, the Board administered an oral examination for international medical graduates. In 1999 that examination was eliminated. Collaboration among the states has been facilitated with the implementation of the USMLE, the national examination that was developed and is administered by the FSMB and National Board of Medical Examiners. These organizations validate the USMLE on an ongoing basis to ensure that the examination is current, valid, and legally defensible. Test material development committees subject test items to critical appraisal; any doubtful items are revised or discarded.

Application Processing

The purpose of the application review process is to scrutinize the qualifications and background of the applicant to ensure that he/she is qualified to practice medicine safely in California. The Board's application review process is administered using the Department of Consumer Affairs' automated Applicant Tracking System (ATS), and requires Licensing Program staff to adhere to the following procedures:

- § Review application and supporting documentation to determine if all statutory requirements have been met.
- § Notify applicant of any application deficiencies. Typical deficiencies may be remedied by submission of further documentation or information, completion of additional training, or taking an examination.

If the application is complete and all requirements are met, the applicant is notified when to expect the license. Section 1319.4 of Division 13 of Title 16 of the California Code of Regulations provides 60 working days from receipt of an application for acknowledgment of the application and provision of information on items needed to complete the file. From the date an application file becomes complete, an additional 100 calendar days are provided for evaluation of the application and a determination as to whether or not a license will be granted.

The number of applications received each year is slowly but steadily increasing:

FY 1997-1998: 4,491

FY 1998-1999: 4,454

FY 1999-2000: 4,644

FY 2000-2001: 5,039

Given the complexity of the process by which application materials are obtained and evaluated, this increase of nearly 15% in workload has had a significant effect on the licensing process. In the past fiscal year, this increase in applications, an increased experience with applications reflecting malpractice and criminal history, significant turnover of trained staff, and a failure to accomplish technology and processing system updates, revealed some systemic weaknesses in the licensing function. To address these issues, the Board engaged in a process review, with consultants from Cooperative Personnel Services, to identify opportunities to enhance the licensing process. Results of that review have led to a re-engineering project, currently underway, that will render significant improvements with a minimal increase in resources being required.

Continuing Education/Competency Requirements

The requirement for continuing medical education (CME) is a long-standing feature of physician licensing. It is based upon the principle that medicine is both a complex and an ever-expanding field that requires physicians to maintain and enhance their skills throughout their careers. To ensure that California's licensed physicians keep pace, the Board requires completion of:

X an average of 25 hours of approved CME each calendar year, and;

X a minimum of 100 hours every four years.

A random audit of the licensee population is conducted each year to verify compliance with the CME requirement; those found to be non-compliant are subject to citations and fines. The Board has made no changes in the CME program since the last review but is currently engaged in a study designed to determine if

there are ways to enhance continued knowledge and competency. The Division of Licensing will address the issue upon completion of the study.

In the conventional meaning of reciprocity, that is to say, a license in one state is fully honored by another, California law does not provide for reciprocity. Section 2135 of the Business and Professions Code, however, provides that a physician and surgeon's license shall be issued to an applicant who holds an unlimited license in another state or Canadian province so long as the license in the other state was issued upon:

- X successful completion of a resident course of instruction equivalent to the required medical school curriculum specified in Business and Professions Code Section 2089, and;
- X taking and passing a recognized written examination.

This pathway is for applicants who have been licensed in another state for four years or more with no disciplinary or criminal history. To qualify under this section of law, applicants must meet one of the following:

- X Certified by an ABMS or approved specialty board;
- X Completed at least two years of accredited postgraduate training, or;
- X Pass the Special Purpose Licensing Examination (SPEX), administered by the Federation of State Medical Boards.

Affiliated Healing Arts Professions:

Over the years, the Legislature has assigned to the Medical Board responsibility for licensing, registering or regulating various affiliated healing arts professionals. Currently, those licensed or registered by the Board are Licensed Midwives, Registered Dispensing Opticians (including Spectacle Lens and Contact Lens Dispensers), and Research Psychoanalysts, as well as regulating unlicensed Medical Assistants.

Requirements for Licensed Midwives:

Education and Experience

The Midwifery Practice Act was chaptered in 1993 and implemented in 1994 with the first direct entry midwives licensed in September 1995 through reciprocity with the State of Washington. Section 2512.5 of the Licensed Midwifery Practice Act of 1993 provides two general avenues for qualifying for licensure. The first outlines a three-year post-secondary midwifery educational program accredited by an accrediting organization approved by the Board. This program includes both academic and clinical instruction. It is important to note that Section 2513 provides

that an approved midwifery education program shall offer the opportunity for students to obtain credit by examination for previous midwifery education and clinical experience. Due to this provision, two methods to qualify for licensure via an educational program have evolved: 1) completion of an approved three-year program, or 2) completion of an experiential program offering credit for previous midwifery training and experience. This latter variation of the program has become known as the "challenge mechanism."

The second route to licensure provided in the law is commonly known as reciprocity. It involves successful completion of a comparable educational program and current licensure as a midwife by a state with licensing standards that have been found by the Board to be comparable to its own.

At present, there are no accredited midwifery educational programs functioning in California and all individuals qualifying for licensure have done so via reciprocity or through the challenge mechanism.

Strengthening Requirements and Verifying Information Provided by Applicants

The first midwifery license application form, implemented in 1994, requested minimal information including name, address, and method of qualifying for licensure. Additionally, applicants were asked to disclose licenses held in other states, disciplinary action, and convictions related to practicing medicine without a license prior to 1994.

The only supporting documents requested were the challenge certificate and NARM examination scores.

In 2000, Section 1379.10 of the regulations was revised to include an updated application form. The revised application asks the applicant to indicate which method is being used to qualify for licensure and requires submission of the following information:

- X college, university, and midwifery programs transcripts;
- X confirmation of satisfactory completion of the Seattle Challenge process;
- X official NARM examination scores;
- X a letter of good standing from each state in which the applicant has held any healing arts license, and;
- X fingerprint cards for both California Department of Justice and FBI processing.

The revised application also includes questions regarding prior professional discipline, license denial, or convictions. Additionally, the applicant's signed statement authorizes the Board to collect information to determine competence and

assess professional conduct or physical or mental ability to engage in practice. The Board's primary sources for verifying information provided by an applicant are the fingerprint clearances and letters of good standing. There is, at present, no national database incorporating midwifery disciplinary data from the various states and jurisdictions.

Examination

The Board uses the North American Registry of Midwives (NARM) written examination to test applicants for licensure. Developed in 1996, the NARM examination has been validated using guidelines of the American Psychometric Association (APA), the National Competency Association (NCA), and the Equal

Employment Opportunity Commission (EEOC). The DCA Office of Examination Resources assisted the Board in identifying and evaluating this examination to ensure that it meets national assessment standards.

The NARM examination is administered nationally twice a year. Schroeder Measurement Technology is the NARM test administrator and uses panels of subject matter experts to prepare and write the examination, using guidelines of the APA, NCA, and EEOC. The skills and knowledge tested are within the midwifery scope of practice and meet California's requirements specified in Business and Professions Code Sections 2507 and 2512.5. Under California law, the examination must be equivalent, but not identical to, the one given by the American College of Nurse Midwives. The NARM examination is the only one that meets this criterion.

Application Processing

As with physician and surgeon applications, the purpose of the review process is to evaluate the qualifications and background of the applicant to ensure qualification for practice in California. Because the volume of applications received each year is very small (average 12 per year), it was determined that it would be cost prohibitive to utilize the DCA Applicant Tracking System (ATS) for the program. For that reason, application tracking and processing is done manually; information is entered into the Consumer Affairs System (CAS) database at the point of licensure.

Individuals inquiring about midwifery licensure are initially screened to determine whether or not they are graduates of approved schools, or must utilize the challenge mechanism. Currently, the challenge program administered by the Seattle Midwifery School is the only one available to applicants. Challenge program participants document previous education and experience. The minimum clinical experiences required are defined in Section 1379.15 of the regulations. Upon review and verification of this experience, candidates must take and pass written and practical examinations developed by the Seattle Midwifery School. Upon successful completion of the challenge program, notification is provided to the Board. The applicant is then provided with the NARM examination application. When a passing examination score report is received, the application for licensure is completed and submitted to the Board for processing.

Section 1379.11 of the regulations provides that the Board shall acknowledge receipt of an application and inform the applicant of items needed to complete the file within 30 days of receipt. Additionally, this regulation requires notification of the licensing decision within 30 days from the date the application becomes complete.

Continuing Education/Competency Requirements

To ensure that licensed midwives continue their education in areas that fall within the scope of practice of midwifery, each licensee is required to complete 36 hours of continuing education during each two-year license renewal cycle. At the time of renewal, licensees are required to certify compliance with the continuing education requirement. Section 1379.28 of the regulations grants authority for an audit, however none has been performed to date.

Reciprocity with Other States

Section 2512.5(b) provides for reciprocity through licensure of individuals licensed other states and who successfully completed an educational program determined by the Board to be comparable to the one required in California law. Currently, Florida and Washington are the only states with approved schools and the only states with which there is reciprocity.

Registration Requirements for the Registered Dispensing Optician Program:

Education and Experience Requirements

A Registered Dispensing Optician (RDO) is any individual, corporation, or firm that is engaged in the business of filling prescriptions of physicians and surgeons or optometrists for prescription lenses and kindred products. As incidental to filling

those prescriptions, either singly or in combination with others, the RDO may take facial measurements, fit and adjust those lenses, and/or adjust spectacle frames. Any business fitting this description must be registered with the Board pursuant to Section 2550 of the Business and Professions Code. The RDO program was established by the Legislature in 1939; in applying for RDO registration, each business location must be registered separately.

No individual may fit or adjust spectacle lenses at an RDO site unless he or she is a registered Spectacle Lens Dispenser (SLD) or is under the direct responsibility and supervision of an SLD. An SLD is authorized to fit and adjust spectacle lenses at any place of business holding an RDO certificate, and whenever spectacle lenses are being fitted or adjusted at an RDO location, a registered SLD must be physically on the premises. To qualify for registration, the SLD applicant must pass the registry examination of the American Board of Opticianry (ABO). Individuals who held the position of manager in good standing on January 1, 1988 were "grandfathered" as spectacle lens dispensers without examination if they applied for registration before December 31, 1989.

Similarly, no individual may fit or adjust contact lenses unless he or she is a registered Contact Lens Dispenser (CLD) or under the direct responsibility and supervision of a

CLD who is physically on the premises. To qualify for registration, the CLD applicant must pass the registry examination of the National Committee of Contact Lens Examiners. A CLD may not supervise more than three Contact Lens Trainees.

The Nonresident Contact Lens Seller Registration Act, effective 1997, implemented registration of out-of-state suppliers of contact lenses. Section 2546.4 of the Business and Professions Code requires submission of an application to accomplish this registration.

Because the statutes do not require any basic education or training to qualify for registration, the examinations required for registration as a SLD or CLD are the essential, primary tools in assuring that the public receives competent service in this area.

Verification of Information Provided by Applicants

SLD and CLD applications require submission of fingerprints for processing at the California Department of Justice and FBI. They also include questions regarding criminal history and prior licensing history either in California or another state. When questions arise, license history verification is requested from other states.

The Board's source for verifying criminal history information provided by an applicant is fingerprint clearance. RDO, SLD, and CLD, and Non-Resident Contact Lens Sellers applications are signed under penalty of perjury.

Examinations

The registry examination of the American Board of Opticianry (ABO) and the Contact Lens Registry Examination (CLRE) are both given in national settings. They are validated every five to six years under the guidance of the Professional Examination Service (PES) that administers both examinations. They were last validated in 1995 through a nationwide survey of practitioners. Additionally, two versions of the examinations are reviewed each year by panels of entry-level, mid-level and advanced practitioners. The pass point for each test version is determined by using three different rating procedures.

Examinations are prepared and written by practicing dispensers, educators and members of the ABO, an independent certifying organization approved by the National Commission on Certifying Agencies (NCCA). The examinations test basic, entry-level, job-related competency in the opticianry field. The high failure rate for these examinations reveals them to be an effective screening mechanism that shields the public from unqualified or poorly qualified practitioners.

Application Processing

Although the registration function is by definition less stringent than the licensing function, the application review process is designed to verify that each applicant has met the statutory requirements to qualify for this line of work in California. Individuals, corporations and firms seeking RDO registration must complete an application process that requires the name under which the RDO will do business as well as disclosure of general partners if the business is a partnership, and corporate officers if the business is a corporation. A separate application is required to register each place of business.

Section 2552 of the Business and Professions Code provides that the Board shall acknowledge receipt of an application and inform the applicant of items needed to complete the file. Additionally, this law requires notification of the licensing decision within 30 days from the date that the application file becomes complete. Similar application procedures exist for SLD and CLD registration.

Continuing Education/Competency Requirements and Reciprocity with Other States

As this is a registration process, rather than one of professional licensing, the law contains no provisions for continuing education or reciprocity with other states.

Registration Requirements for Research Psychoanalysts:

Education and Experience Requirements

A research psychoanalyst is a graduate of an approved psychoanalytic institute who engages in psychoanalysis as an adjunct to teaching, training or research and who holds himself/herself out as a psychoanalyst; or, a student in a psychoanalytic institute who engages in psychoanalysis under supervision. A graduate or student research psychoanalyst must register with the Board to legally practice in California. Physicians and surgeons, psychologists, clinical social workers and marriage, family, and child therapists are not required to register under this law.

There is no examination required to qualify for registration, and the law does not include a continuing education requirement. Since registration is essentially a licensure exemption designed to allow psychoanalysis in a very narrow context, there is no provision in the law for reciprocity with other states.

Application Processing and Verification of Information Provided by Applicants

The application review process is designed to verify that each applicant has met the statutory requirements to qualify for registration as a Research Psychoanalyst in California. The application requires disclosure of criminal history information, and applicants are required to submit official certification of graduation or student status, as the case may be. Fingerprints are submitted for California Department of Justice and FBI clearance and the resulting report is used to verify the criminal history information supplied by the applicant.

Section 1367.4 of the regulations provides that the Board shall acknowledge receipt of an application and inform the applicant of items needed to complete the file.

ENFORCEMENT ACTIVITY

Program Overview

The Enforcement Program of the Medical Board resides within the Division of Medical Quality through its direct oversight of, and establishing policy for, the program. The Division of Medical Quality has the responsibility of enforcing the disciplinary and criminal provisions of the Medical Practice Act; the administration and hearing of disciplinary actions; carrying out disciplinary actions appropriate to findings made by the division or an administrative law judge; suspending, revoking or placing other restrictions on a physician's license after the conclusion of disciplinary

actions; and reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the Board.

The mission of the Enforcement Program - Field Operations is to provide accurate, timely and objective investigations regarding allegations of misconduct by licensees of the Medical Board of California and the Affiliated Healing Arts Professions and to develop information for filing criminal, administrative and civil actions. The Board must not only adhere to the rigid requirements of the Administrative Procedure Act, but must prove violations of the Medical Practice Act (MPA) to a clear and convincing standard (burden of proof) in order to discipline physicians. These facts sometimes create frustrations for the public who expect that any violation should be dealt with swiftly and severely.

Like consumers, physicians and legislators, the Board shares an interest in speedy justice, but is mindful of the due process that must be accorded every person, and its responsibility to meet the legal requirements. The Board is also cognizant that failing to meet these legal demands may result in the Boards inability to protect the public through appropriate disciplinary restraints. Failure also erodes public confidence. With this in mind, the Board pursues each step of the investigative and disciplinary process with the objective of ensuring investigations are completed expediently, accurately and objectively.

The processes and procedures required by this effort are complex. They include not only the analytical, law enforcement, medical and legal expertise available at the Board, but the legal and judicial services provided by the Office of the Attorney General and the Office of Administrative Hearings. The Medical Boards Enforcement Program, that consumes over 70% of the Boards budget and includes the majority of the Boards employees, is easily divided into three basic areas of operation:

- 1) Consumer Complaint Processing and Disposition
- 2) Field Investigation and Prosecution/Adjudication
- 3) Probation Monitoring

Enforcement Data: Physician & Surgeon	97/98	98/99	99/00	00/01
Inquiries	83,869	72,699	69,831	72,533
Complaints received (source):	Total: 10,816	Total: 10,751	Total: 10,445	Total: 10,899
Public	7,041	6,793	6,908	6,846
Licensee/Professional Groups ¹	1,724	1,757	1,656	1,817
Governmental Agencies	1,841	2,045	1,679	1,953
Other ²	210	156	202	283
Complaints Filed, by type:	Total: 10,816	Total: 10,751	Total: 10,445	Total: 10,899
Competence/Negligence	7,255	7,126	6,921	6,581
Unprofessional Conduct	1,894	1,981	1,841	2,650
Fraud	200	172	283	224
Health & Safety	349	340	353	390

Unlicensed Activity	310	349	346	302
Personal Conduct	250	221	244	228
Other/Non-jurisdictional	558	562	457	526
Complaints Closed	8,657	9,024	8,319	7,690
Investigations Commenced	2,154	2,139	2,083	2,320
Compliance Actions:	Total: 470	Total: 498	Total: 382	Total: 638
ISOs & TROs Issued ³	43	62	44	44
Citations & Fines	288	332	250	513
Public Letter of Reprimand ⁴	50	45	56	50
Cease & Desist/ Warning	29	0	9	5
Referred for Diversion	33	27	12	12
Compel Examination	27	32	11	15
Referred for Criminal Action	81	69	61	58
Referred to AG 's Office:	Total: 676	Total: 618	Total: 491	Total: 510
Accusations Filed ⁵	391	392	290	256
Accusations Withdrawn	80	76	71	45
Accusations Dismissed	8	16	12	9
Stipulated Settlements	184	203	200	182
Disciplinary Actions:	383	359	366	288
Revocations	47	48	55	39
Voluntary Surrender	86	77	67	49
Suspension Only	0	3	2	5
Probation with Suspension	19	12	17	16
Probation	108	110	109	91
Probationary License Issued	4	0	2	4
Other ⁶	119	109	114	84
Probation Violations	Total: 14	Total: 24	Total: 31	Total: 16
Suspension of Probation	4	10	10	4
Revocation or Surrender	10	14	21	12

¹ Includes complaints based on reports required by Business & Professions Code Section 800 and 2240(a)

² Includes anonymous and miscellaneous complaints

³ Includes ISO, TRO, Automatic Suspension Orders, PC 23 Orders, Out-of-State Suspension Orders and Stipulated Agreement to suspend or restrict practice

⁴ Includes Public Letters of Reprimand and Public Reprimands

⁵ Includes Petitions to Revoke Probation

⁶ Other includes other decisions, such as requiring an exam or further education, as well as all public reprimands (already listed above in Compliance Actions)

Referencing the Enforcement Data table above, the Board received approximately 75,000 consumer contacts per year with the greatest source of physician complaints coming from the public --- approximately 7,000 of the 11,000 per year. The bulk of the complaints filed against physicians and surgeons involve the quality of medical care rendered, and total approximately 7,000 per year.

Most of the complaints, approximately 8,400 per year, are closed without investigation, as the accused conduct does not meet the standard for disciplinary actions. Approximately 2,100 warrant investigation, and of those investigated, an average of 67 are referred for criminal action, approximately 574 are referred to the Attorney Generals Office for administrative action, and approximately 370 compliance actions are rendered.

In addition to voluntary complaints, the following are some unique reporting mandates, per the Business & Professions Code Section 800 series, that are received by the Board:

- \$ 801 & 801.1: Malpractice settlements over \$30,000 or arbitration awards of any amount from a claim or action for damages, death, or personal injury caused by a licensed physician must be reported by malpractice insurers or state or local government agencies. Reports received in the last four fiscal years: 97/98 - 1,049; 98/99 - 1,041; 99/00 - 982; 00/01 - 921.
- \$ 802 & 803.2: Malpractice settlements over \$30,000 or arbitration awards of any amount from a claim or action for damages, death, or personal injury caused by a licensed physician must be reported by attorneys or employers. Reports received in the last four fiscal years: 97/98 - 213; 98/99 - 287; 99/00 - 196; 00/01 - 391.
- \$ 803: Malpractice judgements for a claim or action for damages, death, or personal injury caused by a licensed physician must be reported by the county court clerk. Reports received in the last four fiscal years: 97/98 - 23; 98/99 - 28; 99/00 - 28; 00/01 - 25.
- \$ 802.1 & 803.5: Physicians must report felony indictments and district attorneys must report felony convictions to the Board. Reports received in the last four fiscal years: 97/98 - 26; 98/99 - 21; 99/00 - 31; 00/01 - 37.
- \$ 802.5: A coroner must report to the Board any findings by a pathologist indicating a death may be the result of a physician's gross negligence or incompetence. Reports received in the last four fiscal years: 97/98 - 41; 98/99 - 26; 99/00 - 29; 00/01 - 33.
- \$ 805: Health Facilities must report disciplinary actions against physicians if the action is for medical cause or reason and the penalty is the suspension, termination or restriction of the physician's staff privileges for 30 days or more. Reports received in the last four fiscal years: 97/98 - 110; 98/99 - 82; 99/00 - 110; 00/01 - 124.

In the past, the Board has experienced significant difficulties in obtaining information from the licensee, licensee's attorney, court clerks, prosecuting attorneys, and coroners, and in obtaining medical records from hospitals for investigative purposes. While the Board generally eventually obtains the necessary information or records, this difficulty often creates delays. The Board regularly contacts the offices of the district attorneys, court clerks, and coroners to remind them of their reporting responsibilities. When hospitals or physicians delay or refuse to comply with records requests, enforcement subpoenas are used, which, while effective, result in further delays. To minimize the delays, investigators immediately follow-up with site visits and calls to the record-holder once the deadline for compliance has passed. If subpoenas are needed, investigators work with the Attorney Generals Office. If the

subpoena does not elicit compliance, investigators and deputy attorneys general immediately file for an order in Superior Court.

Complaints, Investigations, Accusations and Discipline

As the following table shows, on a four year average, of complaints received, 79 percent were closed, 20 percent were referred for investigation, 3 percent went to accusations, and 3 percent went to disciplinary action. Since the last Sunset Review in October 1997, the percentage of complaints found to merit investigation and those resulting in disciplinary actions have remained at approximately 20% and 3%. It is important to note, however, that these percentages are averages based on the numbers of received and closed cases, and are not numbers reflecting same cases in one year, as most are not opened and closed in one reporting year. (A case opened in February of 1998 and closed in July of 1999 will appear as a complaint received in the 1998 year, but will be reflected as closed in the 2000 reporting year.)

NUMBER AND PERCENTAGE OF COMPLAINTS DISMISSED, REFERRED FOR INVESTIGATION, TO ACCUSATION AND FOR DISCIPLINARY ACTION				
Fiscal Year	97/98	98/99	99/00	00/01
Complaints Received	10,816	10,751	10,445	10,899
Complaints Closed	8,657 B 80%	9,024 B 84%	8,319 B 80%	7,690 B 71%
Referral for Investigation	2,154 B 20%	2,139 B 20%	2,083 B 20%	2,020 B 18.5%
Accusations Filed	391-- 3.6%	392 B 3.6%	290 B 3%	256 B 2.3%
Disciplinary Action	383 -- 3.5%	359 -- 3.3%	366 B 3.5%	288B 2.6%

Case Aging

Complaint processing by Enforcement Program staff occurs in various stages. All physician and surgeon complaints are received in the Central Complaint Unit (CCU) and are assigned to a Management Services Technician (MST) staff person within one day of receipt by the Board. MST staff enter the complaint onto the Consumer Affairs System (CAS) automated tracking system, and generate an acknowledgment letter to the complainant within three to five working days.

After complaints are initially handled by the CCU, they may be referred to one of the Boards 12 District Offices for investigation, or Aformal@ complaint handling. These cases are handled by a field investigator. Investigations become the responsibility of district office staff to resolve and/or refer for administrative, criminal or civil action. (See table below.)

Referencing the Case Aging Data table, the numbers are an average of processing days of the four years, and include: 52 days to process a complaint; 241 days to investigate a complaint; 101 days from completed investigation to formal charges filed; 411 days from formal charges filed to conclusion of disciplinary case; and 997 days total (approximately 3 years) from the date a complaint was received to the date of final disposition of a disciplinary case. A positive change from the last review is an 132-day decrease in average total days to complete an investigation from fiscal year 96/97 to 00/01, due to the efforts of investigative staff trying to meet the six month turnaround time for investigations.

AVERAGE DAYS TO PROCESS COMPLAINTS, INVESTIGATE AND PROSECUTE CASES				
Fiscal Year Ending	97/98	98/99	99/00	00/01
Complaint Processing	56	53	44	53
Investigation	313	243	206	204
Pre-Accusation*	110	83	97	112
Post Accusation**	448	343	412	439
Total Average Days***	1,101	996	954	937

* From completed investigation to formal charges being filed

** From formal charges filed to conclusion of disciplinary case

*** From date complaint received to date of final disposition of disciplinary case: The numbers are not the sum

because the discipl

Completing Investigations, Attorney General Actions, and Discipline

Complaint handling and investigations comprise the majority of the Boards enforcement activities. The following figures demonstrate the four-year average number of cases and days involved from opening to completion of an investigation: 769 were closed in 90 days, 417 were closed in 180 days, 575 were closed in one year, 414 were closed in two years, 110 were closed in three years, and 19 investigations took more than three years to complete. An investigation is resolved when it is closed without action, an administrative citation and fine is issued, or the case is referred to the Office of the Attorney General for action.

Processing time delays occur for one or more reasons. After an investigation is referred to the Attorney General, there are many factors that influence the timeliness of the case. One major factor contributing to delay is that cases brought against physicians result in a vigorous and lengthy defense being mounted. This results in protracted legal encounters that can defer final outcomes for a considerable period of time. In an effort to streamline this process, the Board has been working with the

Attorney Generals Office and the Office of Administrative Hearings to hold settlement conferences shortly after an accusation is filed and to schedule the administrative hearings as quickly as possible, depending on the calendars of the participants. These efforts are designed to eliminate the unnecessary passage of time whenever that can be controlled.

Occasionally, when an administrative case is pending against a physician, and the same allegations are pursued criminally by a criminal prosecutor (e.g., District Attorneys Office), the prosecutor may request that the Board delay its administrative case action until the criminal case is resolved so as to avoid a *collateral estoppel* situation which may compromise their criminal case. The doctrine of *collateral estoppel* provides that issues argued and decided in one proceeding cannot be relitigated in a subsequent proceeding.

Of the cases that were referred to the Attorney Generals Office, on a four-year average, 575 cases were closed in one year, 414 cases were closed in two years, and 129 cases took more than two years to complete. (Again, the numbers on the table below are based on the numbers of received and closed cases in one reporting year and do not reflect the same cases opened and closed in one year. Most cases are opened in one reporting year and closed in another. For purposes of this report, Aclosed@ means fully adjudicated, withdrawn or rejected.)

Investigations Closed Within:	97/98	98/99	99/00	00/01	Average % Cases Closed
90 Days	702	781	691	902	33.3
180 Days	371	482	416	399	18
1 Year	528	631	544	596	25
2 Years	514	444	280	418	18
3 Years	221	112	50	58	5
Over 3 Years	55	18	2	1	<1
Total Cases Closed	2,391	2,468	1,983	2,374	
AG Cases Closed Within:	97/98	98/99	99/00	00/01	Average % Cases Closed
1 Year	262	252	221	171	49
2 Years	136	153	172	136	32
3 Years	47	40	47	63	11
4 Years	31	10	12	18	4
Over 4 Years	26	15	17	11	4

Total Cases Closed	502	470	469	399	
Disciplinary Cases Pending	543	546	466	510	

Citation and Fine Program

As previously shown, pursuit of administrative action against a licensee is time consuming. In 1993, the Medical Board recognized that in its history, there were only two basic methods of handling complaints, i.e., close the case or refer the case to the AG for administrative prosecution (or refer to the DA for prosecuting criminal violations). The Board believed there should be some middle ground in dealing with complaints of more minor violations through options that provided some measure of public protection without the filing of expensive and time-consuming administrative accusations.

Today, there are options the Board can pursue such as the issuance of a Public Letter of Reprimand (PLR) or a Citation and Fine. These options became available in 1994 and have proved to be a highly efficient and effective means of providing public protection in a more equitable fashion. The Citation and Fine Program is an alternative method by which the Board can impose a sanction and take an enforcement action against a licensed or unlicensed individual who is found to be in violation of a law or regulation governing the practice of medicine. Citations are issued for relatively minor violations of law and the amount of the fine varies depending on the severity of the offense. Payment of the fine is not an admission of guilt, but does represent resolution of the matter. Orders of Abatement, which essentially are citations without a fine, are a means of obtaining compliance on relatively minor offenses without having to expend resources on a time-consuming and expensive administrative actions.

An average of 346 citations were issued to physicians during the four-fiscal year period and 171 citations with fines were issued during the same time frame. The total amount of fines collected during that time was approximately \$64,000 per year. The Board has used the Citation and Fine Program most frequently to cite physicians who have violated laws that do not pose a threat to the public health or safety. (e.g. records violations, technical violations of advertising laws, etc.)

The Citation and Fine Program has proven to be a successful program for the Board and has seen a substantial increase in amounts collected since the previous Sunset Review. During fiscal year ending 2001, 200 citations with fines were issued and \$68,525 was collected; a substantial increase from 1995 when 57 citations were issued and \$25,300 was collected. There has been one significant change to the public disclosure policy since the previous Review. A copy of the citation will be provided

to any inquiring member of the public. However, citations are purged from public records five years from the date of resolution, unlike in the past, when citations were purged five years from issuance.

Citations and Fines	97/98	98/99	99/00	00/01
Total Citations	288	332	250	513
Total Citations with fines	157	155	174	200
Amount Assessed	\$122,800	\$107,500	\$115,700	\$145,250
Reduced, Withdrawn, Dismissed	\$58,250	\$32,626	\$39,675	\$36,025
Amount Collected	\$50,700	\$71,183	\$65,550	\$68,025

Diversion Program

The Diversion Program, recently entering its 22nd year, continues under its legislative mandate to seek ways and means to identify and rehabilitate physicians with impairment due to abuse of alcohol or other drugs, or due to mental or physical illness. The Programs mandate and mission includes encouraging impaired physicians to seek early assistance to avoid jeopardizing patient safety while ensuring the return of rehabilitated physicians to the practice of medicine in a manner which promotes consumer protection and safety.

The Diversion Program is a statewide, highly structured, multi-faceted, five-year monitoring and rehabilitation program administered by the Division of Medical Quality of the Medical Board. The mission of the program is to protect the public in an effective manner by:

- § helping physicians with alcohol and other drug addictions and/or mental disorders to obtain appropriate treatment;
- § monitoring the ability of program participants to safely practice medicine; and,
- § maintaining a high level of supervision of the participants' treatment and recovery programs to promote ongoing recovery and reduce recidivism.

Costs of the Program:

The costs of the Diversion Program to the Medical Board, over the past four years, on a yearly basis, are demonstrated by the following tables and information:

Diversion Costs to the Board:				
96/97	97/98	98/99	99/00	00/01
\$786,000	\$794,325	\$804,000	\$750,229	\$936,227

The costs associated with the administration of the Diversion Program are funded by the Medical Board through physician license and renewal fees. Participants in the Program are responsible for any treatment and recovery-related expenses such as hospitalization, drug testing, group meetings, individual therapy, evaluations, personal physician care, etc. Participants pay the group facilitators \$165 to \$235 per month for their services. Approximately \$50 per test is paid by the participant for urine drug screens (including observed collection). Inpatient treatment programs cost the participants approximately \$6,000-\$30,000 per 30 days of treatment. No participant is turned away from the program for an inability to pay. Because of the strong relationships built between the treatment community and the program, treatment is sometimes offered pro bono from the community, and no Board funds are used to subsidize the treatment provided.

Referral to the Program:

Physicians enter the Program by one of three methods. First, physicians who do not have any Enforcement action against them, may self-refer. Currently, 61% of participants are self-referrals and enter the Program at the urging of a hospital, colleague or family member. Their identity remains confidential from the Enforcement Program of the Board. Second, physicians may be referred by the Enforcement Program in lieu of pursuing disciplinary action. Finally, physicians may be directed to participate by the Medical Board as part of a disciplinary order. All physicians receive the same level of monitoring regardless of the manner of referral.

The following table shows the number of physicians who have been monitored in each of the last four years:

Physicians Monitored:			
97/98	98/99	99/00	00/01
274	289	299	382*

*Beginning Fiscal Year 00/01, includes 41 applicants in the evaluation process and 12 out-of-state participants.

Benefit to the Consumer:

X **Successful Rehabilitation**

Of the 1,062 physicians who have chosen to participate, 73% have successfully completed the Program. Successful completion is achieved through maintaining continuous sobriety for a minimum of three years, demonstrating changes in lifestyle that will maintain ongoing recovery and, participation in the Program for five years.

The following table shows the number of participants who have completed the Program in each of the last four years:

Number of Diversion Participant Completions:				
	96/97	97/98	98/99	99/00
Successful:	37	34	27	49*
Unsuccessful:	20	18	16	7

* Beginning Fiscal Year 00/01, includes 3 out-of-state participant completions.

X **Prevention of Consumer Harm**

By encouraging physicians to enter the Diversion Program prior to complaints being filed, it is believed many violations and crimes are prevented. As of June 30, 2001, 61% or 167 of 273 active participants are self-referrals who have no open investigations or disciplinary action by the Medical Board.

X **Temporary Practice Restrictions**

While participating in Diversion, physicians are asked not to practice medicine for those periods of time necessary to ensure public protection and/or to aid in their recovery. In addition, restrictions may be imposed as to the number of hours worked, practice settings, prescribing practices and procedures performed. Many of the restrictions are imposed as part of the treatment and recovery plan as well as for strict public safety reasons. The following table shows the number of physicians whose practice was stopped or restricted:

Diversion: Practice Restrictions				

	1997	1998	1999	2000
Stopped	56	62	74	113
Restricted	15	17	42	99

Response to 1997 Sunset Review:

Responding to the 1997 Sunset Review Committee Hearing, the Board's Division of Medical Quality created a Diversion Task Force in February 1998 to undertake an extensive review of the operation of the Program. The intention of the Division of Medical Quality was that improvements to the operation of the Program would be recommended based on this review and that areas allowing for improved consumer protection would be identified. In 2000, the Task Force became a standing committee which meets regularly to ensure continued oversight of the program.

Areas of concentration were:

§ Relationship of Diversion to Enforcement

The Medical Practice Act was amended, effective January 1, 1999, to allow program records (excluding alcohol or drug treatment records) to accompany the notification of Enforcement when participation has been terminated unsuccessfully. Also in 1999, an interim application agreement was developed for use in cases where a physician under current investigation has applied to participate in the Program agreeing that program records may be provided to Enforcement if the physician is not accepted into the program or is terminated from the program for failure to comply with program requirements.

§ Monitoring of Participants

Case Manager contact with participants has been identified as a reporting requirement in the continuous Quality Review process, which, among other things, includes data on intake processing, drug screening, contact with case managers, success and outcomes, as well as information on relapses.

§ Frequency of Screening Tests

In 1998/99, an informal study was conducted which revealed that fewer relapses occurred when testing was more frequent. In 2000, the minimum number of random drug screens for physicians in their first three years of participation was increased. Upon entry into the program, participants are randomly lab tested a minimum of four times each month. After two years, testing may be reduced pending individual case review.

§ Recidivism

In 2000, the statutes were changed to allow maintenance of confidential records for use in statistical studies and data compilation. Success/Outcomes were identified as a reporting requirement of the continuous Quality Review process.

§ Role and Function of the Diversion Evaluation Committees

Legislative changes effective January 1, 2001, shifted the decision-making authority from the Diversion Evaluation Committees to the Diversion Program Administrator. Recognizing the value of their expertise, the Diversion Evaluation Committees continue to assess, review and make recommendations regarding acceptance into the Program, terms of participation and completion or termination from the Program.

§ Qualifications of Facilitators

Consistent with recommendations made by earlier reviews, all fourteen of the current Group Facilitators are now licensed by the Board of Behavioral Sciences or are Certified Alcohol and Drug Counselors.

§ Cost

The Program continues to be a cost-effective alternative to discipline as well as an effective method for monitoring rehabilitation and the safe practice of medicine. The cost to participants has increased minimally within the past twelve years as a \$7 increase in the lab fee and the collection monitor fee was effected in 2000.

§ Payment of Facilitators

Concern regarding the potential conflict as a result of direct payment of Group Facilitators by program participants has been diminished following a thorough review of the decision-making process within the Diversion Program. After examination of the relationship between participants and facilitators, it was found that there was no conflict, as these facilitators have no decision-making authority within the process.

§ Outreach

The Board communicates the existence of the Diversion Program to its licensees through several outreach strategies, such as the following:

- 1) The quarterly *Action Report*, mailed to all licensees and interested parties, carries ongoing information about the Program;
- 2) Diversion Program staff make presentations to hospital well-being committees, medical staff, medical schools and other outside groups;
- 3) Board investigators refer licensees whom they suspect may have a substance-related problem;
- 4) A multi-page program brochure is widely distributed throughout the medical community; and
- 5) The Diversion Program is included in the Medical Board's Web site along with a complete copy of the program brochure which may be downloaded.

During Fiscal Year 1999-2000, the Task Force conducted a side-by-side comparison of the Program with a draft document entitled *Guideline for the Regulatory Management of Chemically Dependent Healthcare Practitioners*, prepared by the Citizen Advocacy Center, a national training, research, and support network for public members of healthcare regulatory and governing boards. At its meeting in February 2000, the Task Force found that the Program policies meet or exceed the guidelines in most areas and also began to identify a need for ongoing Quality Review reporting. In May 2000, reporting requirements were identified in the areas of: Relapse, Drug Testing, Case Manager Contact, Group Meeting Attendance and Success/Outcomes. Ongoing reporting in these areas began in July 2000 at the final meeting of the Task Force. The newly formed standing Diversion Committee held its first meeting in November 2000 and continues to meet on a quarterly basis in conjunction with regular meetings of the Medical Board.

Diversion Program Statistics Summary	97/98	98/99	99/00	00/01
Total Program Costs	\$794,325	\$804,000	\$750,229	\$936,227
Total Participants	274	289	299	382*
Successful Completions	37	34	27	49**
Unsuccessful Completions	20	18	16	7

* Beginning fiscal year 00/01, includes 41 applicants in the evaluation process and 12 out-of-state participants.

** Beginning fiscal year 00/01, includes 3 out-of-state participant completions.

Consumer Satisfaction

As part of the 1997 Sunset Review process, the Medical Board conducted a consumer satisfaction survey. The results were alarmingly poor, showing that most of those

filing complaints were highly unsatisfied with their contact with the Board. This result was not entirely surprising. Most who file complaints will not obtain the results they seek, that is to say, the formal discipline of a physician. While one could expect dissatisfaction with the outcome, the Board could certainly do better in working with and communicating with the consumers through the complaint process.

Following the Sunset Review, the Board made a number of changes to the process. While it could do little to change the outcome of cases, it could, however, be more sensitive and communicative with those who file complaints. For that reason, the Board developed a number of brochures explaining the process. Now, when a complaint is made, three brochures are used. The first is AHow Complaints are Handled@ which gives consumers an overview of what steps will be taken to process their concerns, and what circumstances must exist for disciplinary action to be taken. Other brochures used, when appropriate, are AQuestions About Investigations@ and AMost Asked Questions About Medical Consultants.@

In addition to the brochures, the Board initiated changes in its system to better communicate with individuals who complain to better inform them of the status of their complaint. When a complaint is made, the person is sent a letter acknowledging the complaint and briefly explaining what will be done. Letters are sent at various intervals of the process as well, such as notifying them that their medical records are undergoing a review of a medical consultant. When findings are made, a letter is sent explaining them. Consumers are notified when their complaint is sent on to investigations, and investigators make personal contact with them and keep them informed of their process, unless it is inappropriate for the investigation. When accusations are filed, the person complaining is notified and kept informed of the process. When cases are closed without any action, consumers are told why and any further recourse they may have, including how to file an appeal.

The majority of cases that are rejected for investigation or prosecution because the violation alleged is not a violation of the Medical Practice Act, or does not rise to the level needed to take legal action. The level of the standard of proof is difficult to meet, and physicians are not disciplined for being insensitive, rude or incommunicative. While that behavior causes patient dissatisfaction, it is not illegal nor is it a disciplinable offense. The Board makes every effort to fully explain the process and provide guidance to the consumer. After changes were made in the process in 1997, the Medical Board conducted a survey to evaluate the effectiveness of the changes. In 1999, the Board surveyed randomly every fifth case closed in the 1998 year. While there were still a high number of persons dissatisfied with the outcome of their complaint, there was significant improvement in communication with those who complained. (Note: In the chart that follows, 1998 Survey does not show a Ahigh, average, or low@ satisfaction category, as the surveys were sent only with Ayes@ or Ano@ questions.)

At the request of the current Sunset Committee, surveys were sent to a random sample of one fifth of consumers with closed cases in the 1997, 1999, and 2000 year. Again, the figures show an improvement in communication, but a dissatisfaction with the outcome.

While it is unlikely that consumers will be satisfied with no discipline being taken against those about whom they complain, the Board has and is making every effort to improve communication and treat everyone who complains with sensitivity and respect.

CONSUMER SATISFACTION SURVEY RESULTS:	1997			1998		1999			2000		
	Low	Ave.	High	No	Yes	Low	Ave.	High	Low	Ave.	High
Were you satisfied with the information/assistance provided by our staff?	47%	38%	15%	20%	80%	35%	37%	28%	19%	47%	34%
Were you satisfied that the information/advice received on the handling of your complaint; was it complete/understandable?	67%	22%	11%	56%	44%	54%	31%	15%	47%	31%	22%
Were you kept informed about the status of your complaint during:											
<input type="checkbox"/> Initial complaint review?	77%	15%	8%	44%	56%	58%	28%	14%	45%	33%	22%
<input type="checkbox"/> Investigative process?	83%	11%	6%	70%	30%	71%	17%	12%	42%	28%	20%
<input type="checkbox"/> Disciplinary process?	92%	2%	6%	60%	40%	80%	10%	10%	68%	17%	15%
Were you provided with clearly explained information about the outcome/findings?	69%	19%	12%	72%	28%	65%	22%	13%	57%	27%	16%
Were you satisfied with overall service provided by the MBC?	76%	15%	9%	69%	31%	65%	20%	15%	60%	25%	15%

ENFORCEMENT EXPENDITURES AND COST RECOVERY

Average Costs for Disciplinary Cases

The following figures are an approximation of the costs incurred by the Board for investigations over the past three years. The cost per investigation was derived by dividing the total number of investigations completed during a fiscal year by the total budget amount for investigation processing. Investigations and experts cost an average of \$12.4 million per year. Approximately 2,300 cases were closed per year during the four-fiscal year period with the average cost per case running at \$5,615.

Additional costs are incurred when an investigation is referred to the Office of the Attorney General and also require the involvement of the Office of Administrative Hearings. The average cost per year spent on prosecution and hearings was \$7.3 million. Approximately 595 cases were referred to the Attorney General per year during the four-fiscal year period and the average cost per case was \$ 13,125. Combining the Boards investigation costs with prosecution costs, the average cost per disciplinary case, per year, totals \$18,740.

Average Cost per Case Investigated	97/98	98/99	99/00	00/01
Cost of Investigation & Experts	\$12,096,000	\$12,584,000	\$12,616,000	\$14,467,000
Number of Cases Closed	2,423	2,493	1,995	2,374
Average Cost per Case	\$4,992	\$5,048	\$6,324	\$6,094
Average Cost per Case Referred to AG	97/98	98/99	99/00	00/01
Cost of Prosecution & Hearings	\$7,429,000	\$7,273,000	\$7,323,000	\$7,562,000
Number of Cases Referred	676	618	491	510
Average Cost per Case	\$10,990	\$11,769	\$14,914	\$14,827
Average Cost per Disciplinary Case (Board + AG)	\$15,982	\$16,817	\$21,238	\$20,921

Cost Recovery Efforts

The Board implemented cost recovery beginning in fiscal year ending 1993 with the passage of Assembly Bill 2743. This effort was supported and enhanced as a result of the 1995 report of the State Auditor, titled, *The Medical Board Needs to Maximize Its Recovery of Costs*. Individual cost recovery assessments average approximately \$7,500, and range from \$200 to \$82,000. To enhance collection prospects and avoid the creation of an unreasonable burden on the licensee which cannot be met, the Board accepts cost recovery payment plans which spread receipt of the recovery amounts over months or years. Understandably, this results in larger outstanding balances than would otherwise exist, but does not represent payment Adefault.@ The following figures include the amounts the Board received in cost recovery during the past three years.

During the four fiscal year period, total enforcement expenditures ran approximately \$22.6 million per year. This is a slight increase from the amount of \$21.9 million per year spent over the period reported in the last Sunset Review. An average of 349 cases per year were deemed potential for recovery, i.e., those cases in which disciplinary action has been taken based on a violation, or violations, of the License

Practice Act. During the same period, the actual number of cases that recovery was ordered, on average, was 197 per year and the actual amount of recovery costs collected was approximately \$834,000 per year.

Since the inception of the cost recovery program until fiscal year ending 2001, the amount recouped by the Board increased significantly. The following reflects some of those amounts recouped through the cost recovery process: fiscal year ending 1993 - \$54,000, 1997 - \$759,000, 1998 - \$696,248, 1999 - \$790,194, 2000 - \$995,364, and 2001 - \$857,790.

Cost Recovery Data	97/98	98/99	99/00	00/01
Total Enforcement Expenditures	\$20,993,000	\$21,223,000	\$21,453,000	\$23,553,000
Number of Potential Cases * for Cost Recovery	383	359	366	288
Number of Cases Recovery Ordered	178	211	207	190
Amount of Cost Recovery Ordered	\$1,177,792	\$1,473,734	\$1,359,243	\$1,436,670
Amount Collected**	\$696,248	\$790,194	\$995,364	\$857,790
<p>* The APotential Cases for Recovery@ are those cases in which disciplinary action has been taken based on a violation, or violations, of the License Practice Act.</p> <p>** The Medical Board also collected criminal cost recover of \$14,426 in FY 97/98, \$26,864 in FY 98/99, \$25,124 in FY 99/00, and \$6,870 in FY 00/01.</p>				

RESTITUTION PROVIDED TO CONSUMERS **Public Protection Versus Damages**

Only rarely does the Board seek restitution for damages done to individual consumers. Historically, restitution for damages caused by substandard or reckless medical practice is handled in superior court, through civil malpractice cases.

The primary responsibility of the Board is to protect consumers from substandard or dishonest practitioners, whether or not damage has occurred. Civil malpractice cases are for the purpose of seeking recompense for damages to an individual, whether or not the conduct poses a danger to the public. Conversely, while substandard care may cause no damage to an individual patient, the conduct may

be potentially dangerous and pose a threat to future patients. (As an example, a simple error or act that is neither legally negligent or incompetent may cause great damage and therefore is legal cause for a large malpractice award or settlement. Conversely, a terribly negligent or incompetent act may not cause any harm in a single instance, and therefore may be subject for discipline, but will not yield any civil award or settlement as no damage was done.)

While the Medical Boards complaint staff often mediates between patients and their physicians on minor, technical issues such as obtaining medical records, they cannot act as mediators to obtain sufficient financial redress for serious damages caused by medical malpractice, such as wrongful death or loss of bodily function.

Restitution Data	97/98	98/99	99/00	00/01
Amount Ordered	\$249,137	\$7,677	0	\$15,115
Amount Collected	0	495	0	0

COMPLAINT DISCLOSURE POLICY:

The Medical Boards Public Information Disclosure Policy provides consumers with information that they can use to help them make informed decisions concerning healthcare. The information serves two main purposes, to inform the public-at-large, and to disseminate information to licensees. Usually, information regarding a physician who has been disciplined is available to the public only after a formal Accusation is filed. The types of information available are listed below. The Board provides information about itself and its licensees in primarily three ways:

1. *Internet* (www.medbd.ca.gov) C The Boards Web site also provides consumer information as well as links to other healthcare-related Web sites of interest to the public. The Boards goal is to use this medium to expand the types of information it has historically made available by linking to agencies that assist consumers in a variety of ways, from verifying board certification to learning more about specific health problems. Online consumer information includes:

- \$ How to file a complaint against a physician
- \$ Verifying the license status of a California-licensed physician
- Links to the following are also included:*
- \$ California Department of Consumer Affairs
- \$ Other Department of Consumer Affairs Sites
- \$ California Government Sites
- \$ Federal Government Sites

- \$ Professional Association Sites
- \$ American Board of Medical Specialties
- \$ Department of Health Services ' Office of AIDS
- \$ Healthcare Service Plans
- \$ Drug Formularies
- \$ Links to other Web sites that provide information on board certification, healthcare service plans, and health insurers

2. *Telephone C* The Consumer Information Unit releases the following information to callers (which also is available on our Web site under individual physician profiles):

- \$ Current status of license and the license number
- \$ Date license was issued and expiration date
- \$ Medical school and year of graduation
- \$ Current address of record
- \$ Any public document filed against a physician and surgeon, including but not limited to, Decision, Temporary Restraining Order, Interim Suspension Order, and Citation or Public Letters of Reprimand
- \$ Medical malpractice judgments or arbitration awards of \$30,000 or more reported to the Board on or after January 1, 1993, and those of any amount after January 1, 1998, including the amount of judgment, the dates of the judgment, the court of jurisdiction, the case number, a brief summary of the circumstances as provided by the insurance company, and an appropriate disclaimer
- \$ Discipline imposed by another state or the federal government reported to the Board on or after January 1, 1999, including the discipline imposed, the date of the discipline, the state where the discipline was imposed, and an appropriate disclaimer
- \$ Hospital disciplinary actions resulting in the termination or revocation of a physicians hospital privileges for a Amedical disciplinary cause or reason,@ reported after January 1, 1998
- \$ California felony convictions reported to the Board on or after January 1, 1993, including the nature of the conviction, the date of the conviction, the sentence, if known, the court of jurisdiction, and an appropriate disclaimer
- \$ Information regarding Accusations filed and withdrawn

*The following information is **NOT** disclosed to the public:*

- \$ Complaints and investigations
- \$ Malpractice filings or settlements

- § Whether a case has been referred to the office of the Attorney General for filing of an Accusation
- § Hospital discipline, unless privileges are revoked

3. *Action Report* C The Boards quarterly newsletter is sent to every licensee, all California state legislators, all California major media, the Attorney Generals Health Quality Enforcement Section, as well as to those on an extensive mailing list to interested parties maintained by the Board. It contains:

- § Final disciplinary actions against physicians, physician assistants, and podiatrists
- § Health-related articles (public health and regulatory updates)
- § Medical Board Annual Report (every October)

California discloses more information than most states about its licensees. The public may request where and when a physician graduated from medical school, whether or not they have been cited or disciplined, whether or not hospital privileges were terminated, all malpractice judgments and arbitration awards, among other information. In addition, the Boards Web site provides a link to the ABMS physician verification service, where prospective patients may check on a physicians board certification.

In 2001, the Medical Board appointed a Committee on Public Information Disclosure. It will review the present information being disclosed to determine if changes are warranted, and how to make the information more meaningful to consumers. (See AEmerging Issues and Trends@ in Part Two, on page 88.)

COMPLAINT DISCLOSURE POLICY:

Type of Information Provided	Yes	No
Complaint Filed		X
Citation	X	
Fine	X	
Letter of Reprimand	X	
Pending Investigation		X
Investigation Completed		X
Arbitration Decisions*	X	
Referred to AG: Pre Accusation**		X
Referred to AG: Post Accusation	X	
Settlement Decision	X	
Disciplinary Action Taken	X	
Civil Judgment	X	
Malpractice Decision***	X	
Criminal Violation: Felony Misdemeanor	X	X

* Arbitration awards reported to the Board after January 1, 1993

** In 1992, the Board adopted a policy to disclose cases that had been investigated and been referred to the AG for the filing of an accusation. The California Medical Association filed suit, gained a restraining order, and, as a result of negotiations, the Board promulgated information disclosure regulations which provide for the disclosure of accusations filed, but not investigations referred to the AG in advance of formal filing.

*** Malpractice judgments reported to the Board after January 1, 1993, are disclosed to the public, while settlements of malpractice suits are not.

CONSUMER OUTREACH, EDUCATION & USE OF INTERNET

The Medical Board has an Information Officer with a small staff that is dedicated to providing information to consumers and the profession through various media. Over the years, the Board has provided direct information to consumers through

brochures and publications, participating in consumer outreach programs in communities, providing speakers to interested groups, as well as working with the various print and electronic media to disseminate information important for patient protection. In recent years, use of the Internet for that purpose has been greatly expanded.

On July 1, 2000, after going through the state-mandated Budget Change Proposal (BCP) and Request for Proposal (RFP) processes, the Board began execution of a contract with a public information/education firm. The purpose of the contract was to obtain professional assistance in increasing public awareness about the availability of the Board and its services, primarily so that the public can make more informed choices about their healthcare. At the same time, the Board wishes to provide further education and information to physicians that can serve to enhance their effective patient care.

This effort has enabled the Board to develop and implement a statewide public awareness project that supports its missions and goals of protecting healthcare consumers. The contractor specifically agreed that the objectives of its work with Board staff would include:

- § Increasing awareness of the existence of the Board and the services available to consumers.
- § Measuring baselines of public awareness of the Board and its roles, as understood by various sub-populations and by other appropriate targets in California (such as under-served geographic areas, ethnic sub-groups, or special need senior populations).
- § Assessing and recommending actions based upon what the public needs and wants from the Board.
- § Promoting the Board's Web site, as well as its toll-free complaint telephone number, its Consumer Information Line, and its TDD telephone numbers as important sources of consumer information or services.
- § Educating persons and organizations to whom a consumer may turn with concerns about healthcare services and the Board's jurisdiction, including appropriate referrals and referral mechanisms. Particular emphasis will be put on seniors, parent-care givers, disabled and ethnic groups.
- § Measuring the public awareness of the Board and its role at each appropriate stage of the campaign.

To date, this effort has resulted in the following:

- \$ Execution of a statewide opinion poll to assess Californians knowledge of and opinions about MBC and its services. This information has been used to develop the concept and key messages for the campaigns public service announcements (PSAs).
- \$ Development of multiple print, TV and radio PSAs. Coordinated and facilitated English and Spanish focus groups to test the effectiveness of each MBC PSA option.
- \$ Creation of a professional-looking, one-page flyer, in English and Spanish, urging consumers to use only licensed healthcare professionals and to check with the Medical Board to assure licensure. This flyer has been used at multiple consumer fairs that Spanish-speaking citizens have attended.
- \$ Development of materials for community-based organization (CBO) outreach and execution of an MBC speakers bureau.
- \$ Development of consumer tip sheets, which provide information on the Board and its services and tips on selecting a physician. These are being printed in English, Spanish, Chinese and Vietnamese and distributed via the CBO outreach and speakers bureau projects.
- \$ Creation of a table top show display for use at consumer fairs and speakers events.

There have been many improvements to the Boards Web site since 1997. The entire site has been restructured with a fresh, logical structure which has improved links for consumers, licensees and applicants. It also complies with the Governors mandated format.

The most frequently used service is the AFind Your Doctor Online,@ which receives approximately 167,000 searches each month. This service provides information on physicians, physician assistants, and podiatrists, including their education, address of record, disciplinary and malpractice history.

AServices for Consumers@ also provides information about filing a complaint, forms and publications, as well as informational materials such as guidelines for prescribing controlled substances, how to chose a doctor, ordering prescriptions online, ordering public documents, and patients access to medical records.

Licensing applicants can also find useful information. Physicians applying for licensure can find information about licensing requirements, the licensing process, and the forms needed for application.

Healthcare facilities often use the Boards License Verification System, which can be accessed by authorized credentialing agents to receive information that is not allowed, by law, to be disclosed to the public, but is needed for professional credentialing. Such facilities, such as hospitals, may obtain hospital disciplinary records through subscribing to the service.

Additional areas of improvements to the Web site include direct links to California Laws and Regulations, and information about the Board, such as its membership, board meetings, employment opportunities, and forms to file a complaint or a change of address.

In the future, additional improvements are planned that will enable the Medical Board of Californias Web content to be searchable from the California homepage and will be the first step to eGovernment implementation. (See Part II, AEmerging Issues and Trends,@ AeGovernment,@ on page 88.)

INTERNET & COMPUTER TECHNOLOGY

USE OF THE INTERNET BY THE MEDICAL PROFESSION AND CONSUMER

The Internet and computer technology are being utilized by physicians and consumers in a number of ways. Consumers are utilizing the Internet to obtain medical information, and in some instances, obtain services. The medical profession has utilized computer technology in their practices as well, most of which have little implications to licensing or enforcement. Issues surrounding Telemedicine and Teleprescribing of drugs, however, are topics that have been addressed by the Board and the Legislature.

Telemedicine: In 1995, the Board held a Summit on Telemedicine that was held at the Capitol to examine the implications of this new technology on the practice of medicine, including promises for more access to care and jurisdictional barriers caused by separate state licensing laws and boards. The Summit featured various speakers from several states, including physicians, representatives of telecommunication firms, and various legal counsels from national organizations, including the Federation of State Medical Boards.

Following the Summit, the Board formed a Telemedicine Committee to further examine the jurisdictional issues. The Federation of State Medical Boards was proposing that all states provide a registration program in-lieu of licensure to enable practitioners to practice over state lines via technology. It was the Federations position that if states did not embrace such a program, the Federal government would pass legislation making it entirely legal without states oversight.

The first task of the Committee was to define telemedicine and evaluate what, if anything, the Board should do to ensure public protection should telemedicine be widely embraced. The Committee decided that telemedicine needed to be divided into two categories:

- 1) Teleconsulting: This was defined as doctor-to-doctor communication, much like what was being done widely by telephone and fax. Teleconsulting was defined as only physician-to-physician, without communication directly with the patient. The consultant does not have authority or responsibility for the diagnosis or treatment of the patient, and, if performed under Business & Professions Code Section 2060, does not require a license.
- 2) Telepractice: This was defined as doctor-to-patient, where a physician, using telecommunication technology, communicates directly with the patient, and has the responsibility for the diagnosis and treatment. Basically, it would be the same as any physician-patient relationship, except that the diagnosis and treatment is performed via telecommunication technology. Under the law, a California license is required.

The Committee concluded by seeking legislation to ensure that there not be barriers to consulting for scientific and scholarly exchanges, and sought the authority to develop a telemedicine registration program in regulations when it became needed. They concluded:

Teleconsulting should be fostered to encourage scientific and scholarly exchange, while ensuring that no loopholes exist that dishonest practitioners could exploit. Current law at the time allowed for consultation, but the members wanted to make clear that the consultant would not be primarily responsible for the care of the patient. For that reason the Board sought legislation to amend Business & Professions Code Section 2060. These amendments made their way into

successful legislation, SB 1665 (Mike Thompson), and became effective on January 1, 1997.

2060. Nothing in this chapter applies to any practitioner located outside this state, when in actual consultation, whether within this state or across state lines, with a licensed practitioner of this state, or when an invited guest of the California Medical Association or the California Podiatric Medical Association, or one of their component county societies, or of an approved medical or podiatric medical school or college for the sole purpose of engaging in professional education through lectures, clinics, or demonstrations, if he or she is, at the time of the consultation, lecture, or demonstration a licensed physician and surgeon in the state or country in which he or she resides. This practitioner shall not open an office, appoint a place to meet patients, receive calls from patients within the limits of this state, give orders, or have ultimate authority over the care or primary diagnosis of a patient who is located within this state.

Although SB 1665 was legislation that contained this amendment proposed by the Board, it was primarily a bill to prohibit insurers from discriminating against telemedicine, and requires payments for services, even if they are performed via telecommunication technology.

Telepractice: Under law, a full license is required to practice medicine, whether or not it is delivered via telecommunication technology. Given the potential of telemedicine applications, the Committee was of the opinion that a registration program would be desirable, rather than full licensure. It was the decision of the members to seek legislation for the Board to have the authority to develop a registration program in regulation. As there was no need for a registration program at the time C there had not been even one inquiry or solicitation, authority to write regulations would give the Board the flexibility to develop a program when it was needed, and alter it when changes were required. As technology and medicine changes rather rapidly, it was the members opinion that regulations would be the best and most efficient vehicle to address telemedicine practice.

The Board obtained an author, and this authority was proposed in SB 2098 (Kopp). Instead of obtaining regulatory authority, however, the Board was given the authority to work with interested parties and propose legislation later (B&P 2052.5).

Supporters of a telemedicine registration program were the telecommunication industry and organizations such as the Center for Telemedicine Law. There was no great demand for a registration program voiced by the medical community or the profession. Practitioners using telemedicine in their practice were generally California physicians treating California patients.

The most vocal opponent to a registration program was the California Medical Association. They opposed any program, other than one that would have identical requirements to licensing and identical fees. The second most vocal opponent was the California Society of Radiologists. Both groups contended that a registration program, if not almost identical to licensure, would put California physicians at a disadvantage and make patients vulnerable to substandard care from outside of California.

After the passage of SB 2098, the Committee met with the interested parties to develop a registration program. As the author and the Legislature had made it clear that the Board would need to work with affected parties, specifically, the CMA, before legislation would be successful, the Board began meeting again in 1997. It solicited input and participation of the registration program opponents.

Little had changed. There was no voice to demand such a program, and the same opposition existed. Without a strong proponent and the remaining opposition from the same parties opposed to the original legislation, it was futile to go forward with developing a registration program that could not be successful. In addition, after a fiscal analysis was done, it was clear that the cost of such a program, particularly if there were few participants, was not significantly less than full licensure.

Online Prescribing:

In 1999, with the introduction of Lifestyle drugs[@] such as Viagra and Propecia onto the market, there appeared to be an explosion in Web sites offering one-stop shopping for the anti-impotence drug, as well as some other drugs to treat hair loss and obesity. To evaluate what needed to be done to address this practice, the Board appointed a Teleprescribing Committee.

California law addresses two elements relevant to Internet prescribing. First, prescribing drugs is the practice of medicine, and to practice medicine in the state a California license is required. Second, in relation to prescribing drugs or devices, California law is clear that a prior good-faith examination is required, and without performing one, physicians are guilty of unprofessional conduct. Business & Professions Code Section 2242 (a) states:

Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without a good faith prior examination and a medical indication therefor, constitutes unprofessional conduct.

Enforcement of the law, as it relates to California-licensed physicians, is routine. If a doctor violates the law, disciplinary action against his or her license will follow. While the law does not specifically address all of the elements needed in an examination, a reasonable person can interpret it to mean more than a series of Ayes@ or Ano@ questions on a questionnaire and a credit card number. Clearly, completing a questionnaire with no tests, no scientific verification or evaluation, cannot meet the good faith examination requirement. In 2000, Senator Jackie Speier authored SB 1828 to provide the penalty of a \$25,000 fine, per occurrence, for those who prescribe drugs over the Internet without prior examination.

Action against physicians operating Web sites in other states is more complex. Many sites advertising Viagra, Propecia, and other drugs are operated outside of California by physicians not licensed by California. While the law is clear that this is a violation of the law, enforcement is not always easy beyond state borders.

Other states have taken action against operators of sites outside of their borders. Several Attorneys General have filed suit and obtained restraining orders against such operations.

The U.S. House of Representatives Committee on Commerce has voiced concerns as well. In letters sent to the Controller General, the Food and Drug Administration, the Federal Trade Commission, and the Attorney General, they correctly observed that regulation and jurisdiction over these sites are fragmented, involving a number of Federal agencies and the states. It was their concern that states will not have the resources or proper regulatory structure to handle problems of this magnitude, and the Federal agency structure does not clearly identify jurisdiction and responsibility. They asked these agencies to report to their Committee on jurisdictional elements of current law, and asked for suggestions on how best to either work together, or develop a new regulatory scheme to enforce Federal law and assist states. Congress held public hearings and authored House Resolution 2763, which voiced its intent to require all such operations to post the name and licensing status, by state, of the physician providing the prescription.

The California Medical Board has similar concerns. While it is responsible for enforcing the laws relating to physician conduct, Internet prescribing overlaps

many jurisdictions, including state pharmacy and Federal agencies. The Board, therefore, must work with the Pharmacy Board, the California Attorney General, appropriate Federal government and other states' agencies for enforcement action.

Because of the many technological and jurisdictional issues involved in Internet crime, in 2001, the Board dedicated one investigation position to Internet crimes by creating an Internet Crimes Specialist. (See AChanges Since the 1997 Sunset Review,@ AOrganizational and Operational Changes,@ AInternet Crime Specialist,@ on page 26.)

PART TWO

ISSUES IDENTIFIED BY THE LAST SUNSET REVIEW

Length of Investigative/Disciplinary Process:

The process of rendering disciplinary action against physicians is long and arduous, and has been the subject of many Board and legislative discussions since the 1980s, including the 1997 Sunset Review.

The average time it takes from the receipt of a complaint to the imposition of a penalty is about two and a half years, which means some take considerably longer. While this is significantly less than it was four years ago, (at that time it was over three years) it still is longer than desirable by the public and consumer advocates, as well as the Medical Board.

The logical question is Awhat takes so long?@ The answer is found in an analysis of the disciplinary process and the due process rights of citizens. Specifically, of the average time it takes from complaint to discipline, only an average of about 25% of the process is consumed by the Medical Boards direct investigative involvement. The remaining time primarily results from the operation of the legal system and the legal process.

In this way, the Medical Board is no different than any other law enforcement agency, and the administrative legal system is no more satisfactory to those who desire swift justice. To put this in a more familiar perspective, a police officer may arrest a suspect the day of the crime, and the defendant is formally charged and arraigned of all relevant violations within a week. Depending upon the venue, the nature of the crime, and the legal counsels involved, it may be a number of years

before a trial is concluded and the judge hands down a sentence. Analogously, the Medical Board investigators are the police, the Attorney General is the district attorney, and the Office of Administrative Law is the court. Justice in the administrative arena is often no more swift than in the criminal or civil courts.

While the Medical Board would not argue against due process, it has been challenging to address the criticism for the length of time taken to render discipline. This has been addressed by working to reduce the amount of time it takes for elements of the process under the Boards control, such as complaint processing and investigations. To illustrate, in 1996, the average days for complaint processing were 64, today, it is 53. In 1996, the average days for investigations were 336, and today it is 204. The Attorney General has done its part to shorten the process as well. In 1996, the AG took an average of 139 days to file an accusation, and in 2001, they only took an average of 112 days, and, as stated previously, the Office of Administrative Hearings has successfully achieved the Legislative requirement of issuing decisions within 30 days after conclusion of the hearing.

Over the years, serious reforms have been implemented, and have shown dramatic results. While the past four years show improvement, compared with the statistics of the early 1990s the reforms are extremely dramatic. In 1991 complaint processing took an average of 223 days, compared with the 53 of today, and investigations 315, compared to the 204 of today. In addition, the Attorney General took an average of over one year to file an accusation, compared to today's average of 112 days.

The improvements made to complaint processing and investigations can be attributed to a number of factors and parties. Lawmakers have improved the process through granting additional fees and authority to the Board, as well as requiring greater accountability. Board members have initiated a number of reforms, such as creating a priority system for screening and processing complaints, standardizing the criteria and use of expert reviewers, promulgating clarifying regulations, as well as working with the Attorney Generals Office on a number of issues to improve communication and accountability. Organizational and procedural changes have also improved the process, including refinement of information systems to obtain greater data and tracking, as well as greater uniformity of staff and investigator training. The present Board membership is equally committed to improving the process, and is actively involved in evaluating the enforcement program and initiating changes to improve safeguards and provide greater public accountability.

Complaint processing and investigations have improved, and while there will be improvements in the future, statistically speaking, they will likely be less dramatic. The Medical Board investigates a number of violations, and some require more time than others. Violations of a more objective nature, such as conviction of a crime or discipline rendered in another state, take less time than those of more complex nature. Making a case for medical quality violations, such as negligence or incompetence, takes significantly more time, as Board staff is dependent upon outside expertise, as well as cooperation and compliance with requests for information, and testimony from witnesses. The time is dependent on many variables, such as quality and quantity of witnesses, number of victims involved, the specialty of practice, and the quality of the medical record. As with any other law enforcement agency, investigators must carefully follow the law to ensure a fair and equitable process, as well as to ensure that evidence will withstand any legal examination and challenge.

The Attorney General's Health Quality Enforcement Section works closely with our investigators. In 1996, the HQES and the Medical Board began a pilot project called DIDO - Deputy in District Office Program. Simply, it placed a Deputy Attorney

General in four of our Boards District Offices to provide day-to-day legal guidance for investigations. It was the hope of the AG and the Board that this kind of relationship would, if not reduce the time spent on investigations, ensure more efficient and legally sound investigations that would be of higher quality. The initial pilot worked, and the DIDO Program has been implemented in all district offices.

Using the DIDO Program as the foundation for new reforms, investigative staff is engaged in a dialogue with the AG's Office to explore methods by which to provide a more vertical prosecution process. While the DIDO Program has been successful, the deputy in the district office may not be the prosecutor in the cases over which he or she provides guidance to investigators. Staff of both agencies are exploring how, with limited time and staff resources, cases can be assigned to prosecutors during an investigation, so that there is consistency throughout the process. The purpose would be to further strengthen the relationship between investigators and prosecutors, to possibly reduce the length of time needed by deputies to prepare accusations and for prosecution, and produce a higher quality product.

Elimination of Registration of Research Psychoanalysts:

At the last Sunset Review, the Committee proposed to eliminate the registration of research psychoanalysts, which drew a vocal response from some of the practitioners. As a result of their protests, the Committee was persuaded to not repeal the portion of the law authorizing their registration.

Although the Committee was persuaded to take no action in this legislative session, discussions with research psychoanalysts raised concerns with the lawmakers because it appeared that these registrants were of the opinion that they were Alicensed@ rather than registered. As research psychoanalysts are not required to pass licensing examinations, complete supervised residencies or clinical postgraduate training, complete continuing education courses for renewal, or any of the other requirements generally associated with licensure, the Committee asked that the Board take steps to ensure that any misconception in this area be remedied.

Senator Greene, Chair of the Committee, wrote the Board, and, in summary, asked the Board to report back to the Legislature on two matters: 1) what steps the Board has taken to Aassure that research psychoanalysts understand that they are not licensed by California,@ and; 2) whether or not the registration should be continued by the Medical Board, or whether it should be moved under the Psychology Board. Senator Greene asked that the Board discuss these issues at a Board meeting, and invite the research psychoanalysts to attend and participate.

- 1) Assuring that Research Psychoanalysts understand that they are Aregistered@:

In response to the Committee ' s first concern, to assure that research psychoanalysts are informed that they are registered and not licensed, all research psychoanalysts were sent a letter on June 25, 1998. (See Appendices VIII) In addition, the registration renewal billing invoices being used were entitled Alicense renewal@ and that form was changed to Aregistration renewal.@¹

¹ The application for initial registration is handled by the licensing staff at the Medical Board, and all forms clearly state registration, not licensure. In addition, the wall certificate issued does not state that it is a license, but instead, states that it is a certificate issued by the State of California and contains a registration number. (This is in contrast to a wall certificate issued to a physician, which clearly states that it is a license.) The renewal applications and wallet size certificates are handled for the Board by the Department of Consumer Affairs through a contract with the Employment Development Department. While the wallet certificate does not indicate that it is a license, and instead contains a Aregistration@

- 2) Continuing the Medical Boards registration of Research Psychoanalysts or moving the program to the Board of Psychology:

In response to the Committees request, a discussion was held at the August 1, 1998 Board meeting. A letter was sent on June 25, 1998 to inform all research psychoanalysts of this meeting and invited them to participate. The members discussed whether it would be preferable for the research psychoanalysts to remain under the Medical Board or to be moved under the jurisdiction of the Board of Psychology.

Many of the Research Psychoanalysts were under the impression that the Medical Board recommended the elimination of the research psychoanalyst registration. In the Board ' s report to the Committee, the Medical Board did not recommend their elimination. Rather, the recommendation to sunset the registration program was made by the Department of Consumer Affairs. Their recommendation was based on the following: (a) there is little consumer protection provided by the program; (b) there have been few complaints received, and; (c) there is minimal work or cost associated with this registration program. The intent of the DCA ' s recommendation was not to prohibit the practice of research psychoanalysts, but that the registration program appeared unnecessary. Because of the laws governing psychology, however, elimination of the registration program would not allow the research psychoanalysts to continue practicing legally unless they were also licensed psychologists or physicians.

Practically speaking, DCA was correct in that there seems to be minimal oversight necessary relating to this class of practitioners. Only one complaint was received in four years, and that was a meritless complaint that the person was practicing psychology without a license. The revenue and cost, when compared with the larger registration or licensing classes, are insignificant, as the revenue produced by registration fees total only about \$2,000 per year and the cost to process the applications is substantially equal to the revenue. The program is of no benefit to the Board, but the minimal cost associated with the program is covered by the fees collected. Preparing to move this program to another agency would most probably create more workload than continuing the registration. Ultimately, the Board recommended to the Sunset Committee that the Board retain the registration of the Research Psychoanalysts, and the Committee agreed.

number, the renewal billing forms have in the past stated that it was a *license* renewal. In April 1998, staff requested that these forms be changed to correctly reflect that it is a registration renewal invoice.

Privatization of Diversion Program & Public Protection:

At the last Sunset Review, members of the Sunset Committee voiced concerns about the Board ' s Diversion Program --- the program that monitors licensees with substance abuse problems, and occasionally, mental illness.

There were two major issues raised. First, whether or not the program should be contracted out, or privatized, and second, whether it provides sufficient public protection.

The issue of privatization was discussed, and then rejected by the Committee. The Diversion Program is essentially a monitoring program, not a treatment program. Treatment is provided by private providers, and participants are responsible for paying for their own treatment, not the Medical Board. The Program staffs ' role is to monitor the physicians ' treatment and recovery process. This monitoring includes the performance of urine screens for drug testing, ensuring that physicians are undergoing and participating in treatment, and, most importantly, that their activities are not a danger to the public.

Relating to the issue of providing public protection, Committee members were concerned that participants were being given safe harbor for violations and not held accountable for their actions. In addition, there were concerns that the Program was not being held to a sufficient level of accountability to the Board, or the public.

The Medical Board members took seriously the Committee ' s concerns, and established a Diversion Task Force in February 1998. It reviewed the operation and policies of the program, and worked to establish procedures and protocols to ensure accountability. Specifically, the Task Force clarified the Program ' s relationship with the Enforcement Program, increased the frequency of drug testing, increased the requirements of qualifications for facilitators, and established the Program Manager as the authority to grant or deny participation or termination. Possibly the most important direction of the Task Force was the establishment of a quality review program and a data reporting system to be used to continually evaluate the effectiveness of the program. These quality review measures were based upon, but exceed, the AGuidelines for the Regulatory Management of Chemically Dependent Healthcare Practitioners@ recognized by the Citizen Advocacy Center, a nationally recognized training and research foundation, and

provides the tools necessary for board members to assess the quality of the program. From these measures, members can assess whether the program participants are compliant in monitoring, the timeliness of actions taken, whether participants are being rehabilitated, and, ultimately whether the public is being protected.

Since the conclusion of the Diversion Task Force's activities, the Board established a standing Diversion Committee, which meets publicly at least four times a year. The data collected and the activities and performance of the program are reviewed at public meetings, and any concerns or suggestions can be discussed by the members or any interested party, including the general public.

The program continues to outreach to the profession to educate and sensitize the medical community about the dangers and signs of substance abuse, and encourage the use of the program as a tool for intervention. Representatives speak to hospital well-being committees, medical staff and medical schools, as well as working with the Board's Enforcement program to encourage referrals. In addition, the Board publishes ongoing information about the program in its quarterly newsletter, distributes brochures, and includes the program information on its Web site.

It is important to note that while a number of Diversion Program participants are ordered to participate as part of disciplinary action, most are in it voluntarily. Without this program, these voluntary participants would not be monitored, and perhaps, would not be treated until there is harm done to a patient. The program, therefore, provides public protection where none would exist, and is in the position to provide intervention before harm occurs.

EMERGING ISSUES AND TRENDS

Dealing with Alternative Medicine:

In 2000, the Legislature passed SB 2100 (Vasconcellos, Chapter 660, Statutes of 2000), the Alternative Medical Practices and Treatment Act. It required the Medical Board and Osteopathic Medical Board to address the emergence of holistic health and consider whether any steps should be taken to redesign their systems to meet the healthcare needs of those seeking alternative medical treatment. In addition, before July 1, 2002, the Board must establish disciplinary policies and procedures to reflect emerging and innovative medical practices. The law directed the Board to solicit participation of interested parties and consult with

technical advisors in the development of these policies. Specifically the Board is directed to assess standards for informed consent and investigations.

In addition, the University of California was requested to review cancer treatments and therapies for the purpose of assisting the Governor and Legislature in assuring that Californians suffering with cancer have the best range of treatment and therapeutic choices. The Board is interested in the work that the University will undertake and will closely follow their findings to determine the impact on current thoughts regarding healthcare standards.

To meet its mandated responsibility of SB 2100, the Board formed a Committee to address the issues in the Legislation. The subject of complementary and alternative medicine is not a new topic for the Board. The Board has been grappling with the issues surrounding alternative medical practice and modalities since 1997. (See Appendices IV, Medical Board Activities related to Alternative Medicine)

At its regularly scheduled meetings, the Board frequently hears from constituents with concerns about alternative medicine, and how the Medical Board views non-conventional medical practice. Most of these constituents would like to see legislation that would grant greater freedom of healthcare choices, including the licensing of certain alternative practitioners, such as Naturopaths. In addition, they would like assurances that the Board will not take action against licensed physicians simply for utilizing alternative methods of treatment.

These issues are complex, and many of them are not within the Board's jurisdiction. The licensing of additional types of practitioners is not within the Board's authority, and would require the will of the lawmakers through legislation. The matter of disciplining physicians for utilizing non-conventional treatment, while within the Board's jurisdiction, is even more complex.

Physicians, when found to have practiced in a grossly negligent or incompetent manner, are disciplined. Generally, these cases involve the misuse of conventional treatment or misdiagnosis, and would not fall into a category of alternative medicine. When physicians using alternative methods are disciplined, which is rare, their case has been handled in the same manner as any other matter involving negligence or competence. That is to say, that the treatment rendered is found to be an extreme departure from the medical standard of care. Medical experts in the appropriate specialty and, more recently, also familiar with alternative medical practices, are called upon to determine whether or not the care was sufficiently

below the standard to merit action against a licensee. The alternative practitioners disciplined by the Board are licensed physicians, and they must meet the same standard as any other licensed physician.

It is not the desire of the Board to deny access to practitioners for those wishing to utilize alternative methods of treatment. The Board, however, has a responsibility to apply an equitable standard for all. The Board, through its experts, only takes action if the care given is found to be grossly negligent or incompetent, or violates the law or regulations.

Part of the discussions of the Board's Alternative Medicine Committee are to determine some guidelines for practitioners wishing to use non-conventional methods and disciplinary and investigative guidelines for cases involving alternative medicine. Issues such as providing patients with full informed consent and expanding the Board's experts in alternative methods are also being discussed.

These meetings have been well-attended by constituents with various opinions and have provided the members with a variety of perspectives. As more and more of California's residents utilize non-conventional medical treatments, these issues promise to be of great importance to consumer protection in the future.

Providing Care to the Underserved:

In 2000, the Legislature passed AB 2394 (Firebaugh), which established a Task Force on Culturally and Linguistically Competent Physicians and Dentists. The intent of the legislation was to address the problem of healthcare access of populations within California who traditionally have experienced either no care, or substandard medical care because of language or cultural barriers.

The Task Force is chaired jointly by the directors of the Department of Consumer Affairs and the Department of Health Services, and the Board's Executive Director is a member, along with others appointed by the Task Force chairs. It must develop recommendations for continuing education programs that include language proficiency standards, identify key cultural elements necessary to meet cultural competency, assess the need for voluntary certification standards, hold hearings and meetings to obtain input from interested parties, and report its findings to the Legislature by January 1, 2003.

As part of this law, a subcommittee was established to examine the feasibility of establishing a pilot program that would allow Mexican and Caribbean physicians and dentists to practice in nonprofit community health centers in California's medically underserved areas. This subcommittee is chaired by the director of DHS, and has eleven members, including the Executive Director of the Medical Board.

The subcommittee has discussed a number of proposals for such a pilot program. There was general agreement that there is a need for such a program to serve in some underserved areas, and that any program should assure that participating physicians meet substantially the same or equivalent requirements as licensed physicians, such as graduation from medical school, passing a competency examination, and completion of adequate clinical training.

While a consensus was reached on many topics, there were five issues on which there was no agreement:

1. The temporary versus permanent nature of a license under the project.
2. The placement of project participants.
3. The means for assuring cultural and linguistic competency of participants.
4. The time to implement the project (short-term, two years or longer terms).
5. Licensing and professional residency requirements for participants.

The Department of Health Services is currently drafting its report and it will be published within the year.

The population of California's uninsured is growing, and has now reached over seven million. While the Medical Board's does not have any jurisdiction over where physicians practice or who they must treat, the Board has been asked by the Legislature to act as an expert on a number of projects relating to providing treatment to underserved populations. Currently, the Board has been working with the Task Force on Culturally and Linguistically Competent Physicians and Dentists and its subcommittee, established by AB 2394 (Firebaugh, Chapter 802, Statutes of 2000), in evaluating the feasibility of a pilot program that would bring healthcare to migrant populations.

The current membership is especially committed to finding ways in which it can assist other agencies, the Administration, and the Legislature in finding solutions to this growing concern. The uninsured population is growing at an alarming rate, and creative solutions are needed to find a way to deliver care to those in need. As

reported within, the Board has a program entitled, AOperation Safe Medicine@ (See page 24.) that is taking action against back-room clinics that provide substandard and often dangerous care to those unable to avail themselves of licensed physicians. While it is necessary to combat dangerous practices, it is equally important to identify solutions to the growing problems of those needing healthcare and finding no affordable service. It will be working in the next year to work to identify solutions, and how the Medical Board can assist those in the Legislature and community committed to finding relief for the medically-indigent population.

A New Board and a New Strategic Plan:

In 2001, the Board was substantially a board of new appointees of a new administration. After July 2001, there will be no board members of the previous administration who participated in the Board ' s last strategic planning.

To prepare the new members for their work on the Board, and to give them a foundation on which to move forward with their own initiatives and strategic planning, a retreat was held in March 2001. Members were given an overview of the Board ' s history, how the legislative and regulatory process works, the operations and function of its programs and staff, as well as an explanation of the initiatives of the prior Board.

Now that the members are acclimated to their duties and authority, they have begun the strategic planning process to focus on finding remedies to current problems and challenges, and to forge different initiatives and identify future priorities. In 2001, the Board will be meeting to begin the process, and a new plan will be drafted by 2002.

The Licensing Application Process and the Review of Licensing Operations:

Over the years, the Medical Board ' s Licensing Program has met the considerable challenge of licensing new physicians so that they may continue in their medical training in California. Our state ' s law allows physicians to practice in clinical training settings without a license for up to three years, but after that time they must become fully licensed to continue. As part of the educational system in the United States, physicians-in-training enter postgraduate training programs on July 1 of each year, and these programs may continue for several years, depending on the nature of the specialty training.

For this reason, it has always been a challenge to ensure that all of those training in California institutions received their licenses by the July 1 starting date.

Applications peak around the end of June, with those applying needing to be licensed by July 1, or they must stop their clinical training. Failure to license these physicians by July 1 not only would impact the individual applicant, but would have a severe impact on California institutions that rely on their participation to provide services.

In 2001, substantial delays were encountered, however, the Board's commitment to ensure licensure by July 1 was met. The Board, however, has recognized that there is a growing application workload that may result in further delays in the future if adjustments and improvements are not made to address it.

To obtain an objective assessment of the Board's Licensing operations, and to solicit expert recommendations for remedies of the problems being experienced, in 2001, the Board contracted with the CPS Human Resource Services. In June, after evaluating the processes of the program, as well as interviewing staff and managers, CPS made a number of observations and recommendations. The most major are:

Observations:

- 1) Licensing applications have grown steadily over the past several years, faster than the rate at which staff reviews and processes applications. Productivity of staff has declined because of a number of factors, mostly because of a recently high rate of staff turnover. Without remedy, future backlogs can be expected.
- 3) There are a number of factors within the process which slows progress, including the need for translation of foreign language documents.
- 4)
- 5) The staff is required to perform a number of tasks that are clerical in nature, and that takes considerable time of the para-professional and professional-level staff.

The computer system, the Application Tracking System (ATS) is the cause of some delays, is often unreliable, and provides management with no reports that are useful to monitor productivity of staff.

Recommendations:

- 1) Routine clerical tasks now being performed by technicians and paraprofessional staff should be shifted to clerical workers.
- 2) Management needs better tools to monitor workload and productivity. If the ATS system cannot be improved and modified to provide managerial reports, then it should be replaced or complemented with a system that can provide a tracking element capable of generating such reports.
- 3) The Board should work with the AMA to allow electronic filing of requests for information on their Web site.
- 4) Perform a number of procedural changes in notification of applicants, and the processing of the applications, and consider moving resources from other sections within the Board ' s staff.
- 5) Update and provide better written instructions to Licensing staff.

The Division of Licensing and its staff will be working to implement all of the recommendations contained in the CPS report. The Board is committed to ensuring that applications are processed timely, and no unnecessary delay is experienced by those in postgraduate training programs in California.

eGovernment:

As discussed in Part One of this report, the Medical Board has and is working to utilize Internet technology to better serve consumers and its licensees. There have been many improvements to the Board ' s Web site since 1997, and the entire site has been restructured with a fresh, logical structure which has improved links for consumers, licensees and applicants.

Currently, the Board ' s Web site complies entirely with the Governor ' s Web Site Styles to include the design and format used by the State of California homepage. This enables the Medical Board of California ' s web content to be searchable from the California homepage and is the first step to eGovernment implementation. In the future, it is the Board ' s hope that it can include all of the following options for users to access twenty-four hours a day, seven days a week:

- \$ Online license renewal
- \$ Application for licensing
- \$ Online complaint filing
- \$ Training for physicians
- \$ Licensing verification for consumers and credentialing agents in Areal

time@ with no lag in time for providing updates to the databases.
\$ Receipt of payment for fees

Our staff is working with the Department of Consumer Affairs to determine what can be done within the Board's resources to expand its services through the Internet. This year, and in future years, the Board will be working to implement changes within the Department's and the Board's technological and budgetary capabilities.

Public Information Disclosure:

As discussed in Part One of the report, the Medical Board discloses information about physicians to the public through telephone, mail, and Internet. Most of the elements disclosed are mandated by California law. The amount of information disclosed, whether it should be expanded or the length of time certain information is available has been the subject of debate, not only by our Board in California, but throughout the nation. In July of 2001, the Board formed a Committee on Public Information Disclosure which will be meeting over the next year to discuss the information provided to consumers, how to make it useful and meaningful, and if changes should be made to provide more information.

Problems and Remedies:

Within this report, the Board has identified certain impediments to enforcement or administration of the law, which ultimately impacts the level of protection extended to consumers. The following are problems which may have some administrative or legislative remedy:

Obtaining Medical Records for Investigation:

As reported in the Enforcement section of this report, investigations are sometimes delayed because of a failure of subjects to turn over medical records. Although this is mandated by law, the Board frequently must utilize subpoenas to obtain compliance. Worse, in some instances, during this time medical records can be destroyed or altered, compromising the investigation. For this reason, the authority to obtain an administrative search warrant to seize records to prevent their destruction or alteration is desirable. This is particularly important because currently there is no search warrant authority available unless there is criminal activity. As can be demonstrated by the statistics contained in this report, very few

cases involving gross negligence or incompetence involve criminal activity. While certain practices may be dangerous or substandard and grounds for disciplinary action, they are not criminal, and, therefore, there is no authority to obtain a search warrant.

Impersonation of a Physician:

At present, there is no statute to address the impersonation of a physician. If the person impersonating a physician actually practices medicine, they may be charged with practicing medicine without a license. In some cases, however, the impersonator is engaging in activity to obtain drugs, perpetrate fraud, or attempting to convince the public of his or her medical credentials. In these instances, it would be a helpful tool to prosecutors to have a statute that simply prohibits the impersonation of a physician.

Unlicensed Practice:

At present, there are two statutes that address the unlicensed practice of medicine. Business & Professions Code Section 2052 is a misdemeanor, and 2053 is a felony, which requires that the practice has the potential for patient harm. As a practical matter of prosecution, it would be desirable for district attorneys to have one statute, a Awobbler, on which to file their charges.

Fine Authority:

As reported in Part One of the report, the Board has been effectively utilizing its authority to cite and fine physicians for relatively minor offenses which would not be appropriate for formal discipline. The fines are generally limited to amounts of \$100 to \$2,500. These fines are assessed in conjunction with a citation for an offense that does not rise to the level of formal disciplinary actions.

In cases where the offenses are egregious, where formal disciplinary action is warranted, the Board, with the exception of failing to file a hospital disciplinary action report or Internet prescribing violations, has no authority to assess fines. In 2000, B & P Code Section 2242.1 was added to grant the authority to the Board to assess a fine of up to \$25,000 per violation for Internet prescribing. The rationale of this change in law, facilitated by SB 450 (Speier; Chapter 681, Statutes of 2000), was that Internet prescribing was an economic crime and should carry an appropriately high economic sanction. In instances of billing or insurance fraud, embezzlement, and extortion, the financial sanction should be appropriate to the ill-gotten gain realized. For that reason, it would be desirable to have increased fine authority in formal disciplinary action for matters of financial fraud.

Authority to Compel Competency Examinations to Diversion Participants:

As explained in Part One, the Diversion Program monitors physicians in their drug or alcohol recovery. This process may take up to five years, and during that time the physician may be focusing on his or her recovery, and may not be practicing medicine. When a physician is released from the program, the Diversion Program is attesting to the physician's recovery, not his or her skill or training level. As some participants may have been out of practice for some time, while sober for many years, they may not be current in medical practice skill or training. For that reason, in instances where physicians have been out of practice, the Diversion Program should have the authority to require a competency examination to ensure that the doctor can safely practice when deemed appropriate from a rehabilitation perspective.

Authority to Compel Psychiatric Examination for Licensing Applicants:

In some rare cases, the Board receives licensing applications from physicians or students who have demonstrated behavior that may indicate mental illness which would prevent them from practicing medicine safely. At present, the Board may request the applicant to voluntarily submit to an examination, but it has no authority to compel an exam. In rare instances, it would be desirable for the Board to have the authority to order a psychiatric evaluation to ensure that an applicant has no condition that would endanger patients.

Retention of Investigators:

The Medical Board has had problems with retaining trained investigators due to financial incentives offered by other state, Federal, and local law enforcement agencies, as well as some made by the private sector. As the Board invests a great deal of time and resources to train investigators, it is particularly frustrating to see them leave the Board's service once they are fully trained and experienced, and therefore desirable to other agencies. Keeping investigation time down and providing quality investigative work is the foundation of the Board's service to the public and consumer protection. Retaining investigators when other agencies are offering larger salaries, better benefits, and lower caseloads has been a challenge to the Board for the past several years. The current State system for setting civil service classifications and salaries for investigators have allowed the creation of different pay incentives resulting from either salary or geographic pay differentials which are not uniformly applied, thereby creating a competitive environment among state departments in recruitment and hiring. For that reason, the Board has been working with the Department of Personnel Administration to obtain competitive salaries and geographic pay differential to retain its trained and experienced personnel.

ISSUES RAISED BY THIS SUNSET REVIEW COMMITTEE

Cosmeticians performing medical procedures and the use non-medical personnel to perform medical procedures:

A question has been raised relating to the use of non-medical personnel and estheticians for some medical procedures.

The practice of medicine and the practice of cosmetology require licenses. Simply, cosmetologists are licensed to perform procedures that are not medical in nature, that is to say, do not treat by penetrating living tissue. The practice of medicine involves procedures involving the treatment of living tissue. A license to practice cosmetology does not license practitioners to practice medicine, nor does a medical license entitle practitioners to practice procedures requiring a cosmetology license.

A good example of this is the practice of laser hair removal. In October 1997, the Medical Board's Committee on Plastic & Cosmetic Surgery discussed this issue and asked counsel to prepare a legal opinion. An opinion was prepared (See Appendices IXa), and, in short, only physicians, nurses, physician assistants and dentists may use lasers, and only within the scope of practice allowed by their licenses. Electrologists, cosmetologists, estheticians, and medical assistants are not legally allowed to use lasers for hair, tattoo, or spider vein removal, or any other cosmetic procedure.

To assure that physicians were fully informed, an article was published in the January issue of the *Action Report*, entitled *The Use of Medical Assistants by Physicians*. (See Appendices IXc.) It was written in compliance with a court order resulting from California Optometric Association vs. The Division of Licensing of the Medical Board of California, that revolved around the issue of using medical assistants for ophthalmic testing. As a result of the legal opinion and the interest shown by the electrologists and physicians desiring to use un-licensed or improperly licensed personnel to perform laser treatments, the article also included broader information about use of unlicensed medical assistants or other improperly licensed personnel. It specifically addressed the issue of lasers and made clear that unlicensed personnel may not be hired for this purpose.

On November 17, 1997, the DCA Barbering and Cosmetology Program met to discuss the issue of laser hair removal. Because the law does not allow any of their licensees to use lasers for hair removal, it was their intention to develop a

legislative proposal to allow electrologists, estheticians, and cosmetologists to use lasers for hair removal under the supervision of a physician. DCA legal staff assisted them by providing assistance with the proposed language, but the private associations were to be responsible for finding an author and seeing the bill through the legislative process. As there appeared to be no consensus among electrologists, cosmetologists, or members of their associations, the profession failed to solicit an author for any legislation to expand the scope of their licenses to allow the use of lasers. Certainly, there are some electrologists that are anxious to expand their practice to include lasers, but many are absolutely and firmly opposed.

Concerned by reports that electrologists are using lasers illegally, the Barbering & Cosmetology Program issued a press release. (See Appendices IXb.) It was distributed to professional journals, and warns that it is illegal for electrologists, medical assistants, or other non-medical licensed personnel to perform laser hair removal. In addition, letters were sent to all of the laser manufacturers, along with the written legal opinion.

The Board occasionally receives complaints about the use of unlicensed personnel to perform laser or other medical procedures. When such a complaint is made, a file is opened and investigated by the Board ' s enforcement personnel, and appropriate penalties follow.

2.

BACKGROUND PAPER FOR HEARING

IDENTIFIED ISSUES, QUESTIONS FOR THE BOARD AND BACKGROUND CONCERNING THE ISSUES

PRIOR SUNSET REVIEW: The Medical Board of California (Board) was last reviewed by the Joint Legislative Sunset Review Committee (JLSRC) four years ago (1997-98). The JLSRC and the Department of Consumer Affairs (DCA) identified a number of issues and problem areas concerning this Board and directed the Board to implement a number of recommendations and changes. Some of these included: (1) to take a number of specified steps to improve the Board's enforcement program; (2) reexamination of the current process which authorizes the Board to issue interim suspension orders; (3) research of an appropriate approach to privatizing the Board's diversion program; (4) providing justification for a fee increase and finding ways to reduce costs; (5) elimination of the Board's oral examination for out-of-state and foreign graduates; (6) for the Board to stay current on the changing and emerging treatment modalities in medicine, including those associated with "alternative medicine," and for the Board to make recommendations to the Legislature on ways to assure the appropriate oversight of those involved in non-traditional, experimental, or alternative medical modalities. The JLSRC also found that there was sufficient evidence to recommend the continued licensure of physicians and surgeons by the Board, but that any new or additional license classifications such as naturopaths, homeopaths, perfusionists, etc., be subject to the mandates of Section 9148 et seq. of the Government Code (This is a "sunrise process" similar to the current sunset review process of the JLSRC, but is conducted by the standing committees of the Legislature.)

In September, 2001 the Board submitted its required sunset report to the JLSRC. In this report, information of which is provided in Members' binders, the Board described actions it has taken since the Board's prior review. The Board addressed several issues presented by the JLSRC and Legislature over the past four years and also implemented some of the following changes pursuant to legislation and on its own initiative since its last review. This included:

- Attempts to increase revenue for enforcement purposes through a fee increase.
- Legislation and regulations to improve the Enforcement Program, including increased penalties for non-reporting of disciplinary actions within health facilities and shortening the period for investigation and prosecution of disciplinary cases. Also efforts to retain trained investigators and deal with the high number of vacancies within southern California district offices.
- Recruiting medical expert reviewers to ensure that medical experts are available to address such areas as the treatment of pain management and use of complementary and alternative medicine.
- An independent review of the Licensing Program to deal with delays in the licensing process.
- Implementing and adopting regulations regarding approval of specialty boards and advertising of board specialties.
- Forming a Plastic and Cosmetic Surgery Committee in 1996, to deal with implementation of laws regarding accreditation of outpatient surgery facilities, reporting requirements of these facilities, misleading advertising associated with plastic and cosmetic surgery, unlicensed

activity, and more recently to adopt standards regarding liposuction.

- Forming a Diversion Task Force to review the Diversion Program and make changes to the administration of the program.
- Forming an Alternative Medicine Committee in 2000, to determine what guidelines may be necessary for practitioners using non-conventional methods and to develop investigative and disciplinary guidelines for cases involving alternative medicine.
- Expansion of the Board's web site along with increased information provided to the public.
- Forming a Telemedicine Committee to address issues involving both teleconsulting (physician-to-physician) and telepractice (physician-to-patient) practice over the Internet.
- Forming a Teleprescribing Committee to address issues involving prescribing and dispensing of drugs over the Internet, and in 2001 dedicating an investigator position to Internet crimes by creating an Internet Crime Specialist.
- Recent participation in efforts to address the healthcare access of populations within underserved areas and those receiving substandard care because of language or cultural barriers.

Beginning on the next page are a number of unresolved issues pertaining to this Board, or areas of concern for the JLSRC, along with background information concerning the particular issue. There are also questions that staff has asked concerning the particular issue. The Board was provided with these issues and questions and is prepared to address each one if necessary.

CURRENT SUNSET REVIEW ISSUES

BUDGETARY ISSUES

ISSUE #1: When will a fee increase for the Board be necessary?

Question #1 for the Board: *Please explain what programs and services will experience larger expenditures in the future. Does the Board anticipate requesting a fee increase sometime in the near future to deal with an overall decrease in its revenues versus increased expenditures by fiscal year 2004/05? Are there any cost saving measures the Board could initiate such as in information technology services.*

Background: Since its last review, the Medical Board has experienced a significant rise in costs without an equal rise in revenue. Additional costs have been incurred in both the investigation and prosecution of disciplinary cases. There is also a legal case pending before the California Supreme Court regarding the ability of boards to collect some of these costs in the future (cost recovery). The Board also indicates that it will face a number of large expenditures in the future for several programs and services, particularly those related to technology. It is anticipated that the Medical Board will have less than one month in reserve by fiscal year 2004/05. It is generally recommended that boards have at least three to six months reserve for exigent circumstances.

LICENSURE ISSUES

ISSUE #2: What is the Board doing to deal with substantial delays in the Licensing Program incurred during the year 2001?

Question #2 for the Board: *Why does the Board suspect these delays were encountered? What does the Board anticipate doing to assure timely licensing of new physician applicants in the future?*

Background: In 2001, substantial delays were encountered in the licensing of new physicians. The Board has recognized that there is a growing application workload that may result in further delays in the future if adjustments and improvements are not made to address it. To obtain an objective assessment of the Board's Licensing operations, and to solicit expert recommendations for remedies of the problems being experienced, in 2001, the Board contracted with CPS Human Resource Services. In June, after evaluating the processes of the program, as well as interviewing staff and managers, CPS made a number of observations and recommendations.

ISSUE #3: Should postgraduate training be increased by one year?

Question #3 for the Board: *When does the Board anticipate the study to be completed and has the Board given any consideration to a "limited license" as is required for podiatrists involved in postgraduate training?*

Background: One year of postgraduate training in an approved postgraduate training program is required for U.S. graduates and two years for international graduates. Nationally, there is some variability with many states requiring two or three years. The Federation of State Medical Boards has adopted a position that full licensure should be delayed until a third year of postgraduate training and urges all states to adopt this standard. During the last review, the JLSRC recommended that the Board not increase postgraduate study to two years because of lack of justification. The Board is currently involved in a study to determine if an additional year of postgraduate training should be required before licensure. Because of concerns regarding the practice of podiatric medicine by those participating in postgraduate training, the Board of Podiatric Medicine requires a "limited license" to provide appropriate oversight until postgraduate training is completed. Might this "limited license" requirement for physicians

allow the Medical Board appropriate oversight of postgraduate training and at least allow certain licensed medical practice to occur, rather awaiting full licensure for two to three years?

ISSUE #4: Should the Board be given authority to compel psychiatric examinations for applicants if there is an indication of mental illness?

Question #4 for the Board: *How would the Board determine that an examination may be necessary and what procedures would it follow to insure that examinations are only required where warranted?*

Background: The Board has indicated it receives licensing applications from physicians or students who have demonstrated behavior that may indicate mental illness that would prevent them from practicing medicine safely. They can request the applicant to submit voluntarily to a psychiatric examination but that it does not have authority to compel an exam. In rare instances, the Board indicates that it would be desirable to have authority to compel this type of examination.

ISSUE #5: Have there been problems with implementing the Licensed Midwives Practicing Act and in defining and implementing the requirement for physician supervision?

Question #5 for the Board: *When does the Board anticipate regulations to be adopted to implement SB 1479? Does the fact that there are no accredited midwifery education programs in California prevent those within the state from qualifying to become licensed midwives or attempting to enter into the profession? What is the Board's official policy on physician supervision? Have licensed midwives been provided clear notice of this policy? Has the Board reviewed the statutory interpretation of physician supervision set out in the Osborn decision? Is the Board's policy consistent with this decision? Are the statutory interpretations adopted by the Board through this decision being adhered to in subsequent interpretations? What is the basis on which the Board continues to pursue disciplinary actions against licensed midwives for lack of physician supervision? Would a different definition of supervision from that defined in the Osborn decision or regulations allow the practice of licensed midwifery in California?*

Background: SB 1479 (Figueroa, Chapter 303, Statutes 2000) increased the requirements for informed consent that licensed midwives must provide to clients and allows midwives to register the birth. The Board scheduled a committee meeting in September 2001 to review these requirements and to discuss possibly regulatory language with interested parties. The Board also indicated that there are currently no accredited midwifery educational programs functioning in California and that all individuals for licensure have done so via reciprocity or through an experiential program offering credit for previous midwifery training and experience called the "challenge mechanism."

California licensed midwives (LMs) are in a difficult position with regards to the enforcement of the physician supervision provision of the Licensed Midwifery Practicing Act (LMPA). On one hand, the LMPA requires all LMs to have physician supervision. This is not defined in statute, rather, the statute only says that supervision “does not require the physical presence of the supervising physician.” On the other, due to liability concerns, no physician will provide supervision or work with LMs who provide community-based birth services. Thus, any time a California LM attends a home delivery, which is exactly what they are licensed to do by the Board, even if the LM has been working with a physician, he/she is without “physician supervision” as interpreted by the Medical Board. Consequently, the LM is in violation of her scope of practice, and may be disciplined by the Board regardless of the outcome of the birth. Although most LMs have an informal consultative relationship with a physician, this had not been considered as “supervision” due to lack of a formal relationship.

However, in August 1999, licensed midwives thought that the problem was resolved when Administrative Law Judge Jaime Roman made a ruling in an administrative law decision which defined physician supervision. Judge Roman ruled that the midwife, Allison Osborn, did nothing wrong in delivering a child without formal physician supervision, because, as he put it, “In an effort to promote the efficacy of the Act, this tribunal concludes, at this time, that a licensed midwife who possesses a relationship with a California physician or surgeon as referenced herein has feasibly and reasonably satisfied the ambit of the Act.” The relationship referenced by Judge Roman is one where LMs, “with the cooperation of physicians sympathetic to their plight and who seek to expand the options available to patients, developed a relationship that involves collegial referral and assistance, collaboration, and emergent assistance without direct or accountable physician and surgeon supervision of licensed midwives.” This interpretation of physician supervision is consistent with the spirit of the law and the practical application of enforcement standards. It upholds the statute while allowing the licensed midwives to practice. Subsequently, the Medical Board of California accepted Judge Roman’s proposed decision and dismissed the case against Allison Osborn. In doing so, California licensed midwives believed appropriately that the Board was thus accepting the decision’s statutory interpretation of physician supervision. Beyond the Osborn decision, and in the absence of regulatory interpretation of physician supervision, no workable definition of supervision exists to orient licensees toward acting within their scope of practice.

The JLSRC has heard from reliable sources that the Board is pursuing disciplinary actions against licensed midwives for practicing without physician supervision. This is troubling to the JLSRC for two reasons. First, by dismissing the case against Allison Osborn, the Board adopted the proposed decision and thus accepted the statutory interpretation of physician supervision offered by Judge Roman. Unless the Board has taken action since accepting the decision to reverse or disagree with all or sections of this decision, one reasons that the acceptance of this decision would demonstrate the Board’s agreement with the principles and interpretation of the decision. If this were not the case, the Board should have disagreed with the proposed decision when presented with it or taken formal steps to overrule it at a later point. To accept the decision, then proceed as if it had never occurred, is terribly confusing to the licensees. Second, granted that information is lacking about current cases, if the Board is continuing to proceed with disciplinary actions against LMs for lack of supervision, with no regard to the statutory interpretation brought forth by Judge Roman, then the Board is acting capriciously and unequally

toward licensees who are merely looking for direction on how to practice their licensed profession without being in violation. Though administrative law cases are not necessarily “precedent setting”, it is disturbing that the Board would accept a statutory interpretation in one case, then apply a different interpretation without basis or logical explanation for the difference in a subsequent and similar case.

ISSUE #6: Is it appropriate for the Board to continue regulating other health care professionals who are not physicians and surgeons?

Question #6 for the Board: *Does the Board perceive any problems with removing the Board’s authority over affiliated healing art professionals and transferring that authority to a new board or bureau?*

Background: Over the years, the Legislature has assigned to the Medical Board responsibility for licensing, registering or regulating various affiliated healing arts professionals. Currently, those licensed or registered by the Board are Licensed Midwives, Registered Dispensing Opticians (including Spectacle Lens and Contact Lens Dispensers), and Research Psychoanalysts. The Board also has responsibility for regulating Medical Assistants. There are also proposals being considered for licensing of health care professionals who are not currently licensed by California, and for the Board to assume responsibility for regulating those professionals as well. With limited resources of the Board currently, and possible budgetary problems in the future, as well as the problems associated with shifting authority of the Board into areas not involving the regulation of physicians and surgeons, it may be time to consider a bureau or board for affiliated healing art professionals and to transfer the authority of the Board over current other health care professionals to this new bureau or board.

ISSUE #7: What is the Board’s involvement in issues related to physician shortages and providing health care to underserved areas?

Question #7 for the Board: *What has been the extent of the Board’s involvement in the issues related to physician shortages and providing care to the underserved areas? What are the Board’s suggestions or recommendations regarding both of these issues? Do discussions involve changing licensing requirements, providing for temporary licensure, changing reciprocity requirements, etc.?*

Background: Recently, there were discussions by the Center for the Health Professions and the California Medical Association regarding physician shortages throughout the State. The Board has also been involved in discussions regarding healthcare access of populations within California who traditionally experience either no care, or substandard medical care because of language or cultural barriers.

ISSUE #8: Could licensing and fee requirements be changes so physicians in retired or inactive status, or whose license has lapsed, could be utilized for state or federal emergencies?

Question #8 for the Board: *Explain how the Board has been approached about this issue. Would it be possible to streamline the licensing process for physicians who are not actively engaged in the practice of medicine so that they could serve in some capacity in a time of state or national crisis? How many physicians currently have lapsed, retired or inactive licenses?*

Background: Both the JLSRC and the Board have been approached about attempting to streamline the licensing process and waiving particular licensing fees and continuing education requirements for licensees who have allowed their license to lapse, or have a retired or inactive license, so as to allow them the opportunity to serve in times of a state or national crisis, or where there is currently a severe need for physicians.

ISSUE #9: Why has the law requiring approval of specialty boards been problematic?

Question #9 for the Board: *What have been the problems associated with implementing this law and are there still outstanding issues or problems to deal with in the future?*

Background: In 1990, SB 2036 (McCorquodale), a bill sponsored by the California Society of Plastic Surgeons, among others, sought to prohibit physicians from advertising board certification who were certified by “weekend boards,” or other entities that were not genuine certifying agents. At the time, this bill was referred to as the “bogus board” bill. The law (B& P Code 651(h)(5)(A)&(B)) prohibits physicians from advertising that they are “board certified” or “board eligible” unless they are certified by an American Board of Medical Specialties (ABMS) specialty board, or a board approved by the Medical Board of California. This law, as indicated by the Board, has been problematic and the subject of four lawsuits since its passage. Despite these problems, however, the Board has attempted to administer this law in a manner that makes it meaningful and helpful to consumers. Since the regulations were adopted, the Division of Licensing of the Board has reviewed a number of specialty board applications. Specialty boards that have been approved by the Medical Board are:

1. The American Board of Facial Plastic & Reconstructive Surgery
2. The American Board of Pain Medicine
3. The American Board of Sleep Medicine

Specialty boards that applied, but were not approved are:

1. The American Academy of Pain Management
2. The American Board of Cosmetic Surgery

Specialty boards approved by the Board mean that they meet training and standards for certification that are deemed to be “equivalent” to an ABMS board, as defined by regulations. Disapproval means that the specialty board failed to demonstrate that they meet the regulatory requirements.

PROFESSIONAL AND ETHICAL PRACTICE ISSUES

ISSUE #10: What studies are being conducted by the Board to improve the quality and safety of healthcare provided to consumers?

Question #10 for the Board: *Please explain the studies which the Board is conducting and how they may improve the overall quality and safety of healthcare received by patients?*

Background: The Board has indicated that they are doing several studies to enhance the quality and safety of healthcare and to reduce medical errors and occurrence of patient harm.

ISSUE #11: Are there problems with the implementation of SB 16?

Question #11 for the Board: *Will the Board still be able to conduct the study on the peer review process and pursue a program to provide practitioner remediation?*

Background: SB 16 (Figueroa, Chapter 614, Statutes 2001) was signed by the Governor this year and was a measure intended to deal with problems associated with the peer review reporting process. However, the Governor indicated in his signing of the bill that the Board must conduct all studies and new programs pertaining to this measure within existing resources. SB 16 required a study to be conducted of the peer review process and for the Board to pursue a program for identifying practitioners in need of remedial training and direct them to effective providers of such training and education. It is unknown whether the Board will be able to conduct the study and proceed with implementation of a remedial training program for physicians.

CONTINUING COMPETENCY ISSUES

ISSUE #12: Are changes needed to the Board's continuing medical education (CME) program?

Question #12 for the Board: *What are the parameters and considerations being made within the study and when does the Board anticipate the study to be completed?*

Background: The requirement for CME is a long-standing feature of physician licensing. To ensure that physicians keep pace with the changing and complex field of medicine, the Board

requires completion of an average of 25 hour of approved CME each year and a minimum of 100 hours every four years. A random audit of the licensee population is conducted each year to verify compliance with the CME requirement; those found not to be in compliance are subject to citations and fines. The Board indicated that it has made no changes in its CME program since its last sunset review, but indicates that is currently engaged in a study designed to determine if there are ways to enhance continued knowledge and competency of physicians.

ENFORCEMENT ISSUES

ISSUE #13: What improvements has the Board made to its enforcement program since its last sunset review four years ago?

Question #13 for the Board: *What improvements has the Board made to its Enforcement Program and what other changes are anticipated to improve the program? How have these changes improved performance of the Enforcement Program in responding to consumer complaints?*

Background: During the prior sunset review, the JLSRC recommended that the Board take several steps to improve its enforcement program. They included: (1) Place Deputy Attorney General's in all of its 12 district offices to speed up and improve its enforcement efforts. (2) Alter legal requirements or procedures, and/or increase penalties for non-compliance with Board subpoenas to obtain medical records and for failure to comply with other reporting requirements in the law, particularly relating to peer review actions. (3) Improve the Board's ability to effectively document data relevant to the Board's specific enforcement functions. (4) Take steps to eliminate the endemic vacancies in the Board's investigator positions, particularly in the Los Angeles area.

ISSUE #14: Are there still problems with receiving information from those who are required to report to the Board regarding malpractice settlements, judgments, felony convictions, etc.

Question #14 for the Board: *Is the Board still experiencing significant difficulties in obtaining information from the various reporting entities, and if so, what changes or improvements can be made to the existing reporting requirements?*

Background: In the past, the Board has experienced significant difficulties in obtaining information which is required to be reported to the Board including malpractice settlements, judgments, felony convictions, findings from a pathologist that a death is a result of physician's gross negligence or incompetence, and reports of disciplinary actions taken against a physician or surgeon by a health care facility. For the past four years, the Board has received on average about 1000 reports from insurers or state or local agencies regarding malpractice settlements over \$30,000 or arbitration settlements, and about 200 to 400 reports from attorneys or employers. It has only received on average about 25 reports of malpractice judgments from

county clerks. It receives on average about 30 reports from district attorneys regarding felony convictions. It received on average about 30 reports from coroners indicating a death of a patient as a result of a physicians gross negligence or incompetence. It received on average about 110 reports regarding disciplinary actions taken against a physician by a health facility. The extent of reporting seems relatively low over the past four years for all of these reporting entities.

ISSUE #15: Why are there fewer disciplinary actions being taken by the Board?

Question #15 for the Board: *Are there reasons why disciplinary actions taken by the Board against physicians may be on the decline?*

Background: For the past eight years complaints have risen significantly, from approximately 8000 in 1993/94 to almost 11,000 in 2000/01. Yet the number of disciplinary actions taken by the Board are beginning to decline, from a high of 383 in 1997/98, to 288 in 2000/01. Is this cause for concern?

ISSUE #16: The disciplinary process of the Board is still rather lengthy, taking on average of about two and a half years from the time a complaint is filed to final disciplinary action?

Question #16 for the Board: *What efforts has the Board made to streamline the process and are there other improvements that can be made to decrease the amount of time it takes to investigate and prosecute disciplinary cases?*

Background: It is still taking on average about two and a half years from the date a complaint is filed till final disciplinary action is taken against the physician. However, the Board has made significant reductions in the amount of time it use to take to process and investigate a complaint, as well as in the time it takes to file an accusation against a physician. Over the past eight years this time frame has been reduced from almost three and half years to the current two and a half years.

ISSUE #17: There is still a high dissatisfaction with the Board by those who file complaints, but the Board has made significant improvements in communicating with complainants.

Question #17 for the Board: *Please explain the effort the Board has made to improve communication with complainants, why dissatisfaction with the outcome of the consumers complaint is still high, and what other improvements the Board intends to make to provide better overall service to the complainant.*

Background: As indicated by the Board, as part of its 1997 sunset review, a satisfaction survey was conducted by the Board as requested by the JLSRC. The results were alarmingly poor,

showing that most of those filing complaints were highly dissatisfied with the outcome of their case (about 75%) and the overall service provided by the Board (about 60%). Since that time the Board has made some strides in attempting to maintain better communication with complainants and the recent survey seems to reflect that effort. About 80% of complainants are satisfied with the information and assistance they receive from staff of the Board, compared to about 53% in 1997, and about 53% are satisfied with the advice they receive on the handling of their complaint, compared to about 31% in 1997. However, there is still a high dissatisfaction with the outcome of their particular case, but improvements have been made. About 35% in 2000 were satisfied with overall service provided by the Board, as compared to 24% in 1997.

ISSUE #18: Currently a physician could be found to have sexually abused a patient and still be allowed to continue to practice.

Question #18 for the Board: *Should the license of a physician be automatically revoked if they are found to have engaged in any sexual exploitation of a patient as defined in Section 729 of the Business and Professions code? Please provide information on the number of cases in which a physician has been found to have violated Section 729 over the past four years and the disposition of their case. What disciplinary action was taken?*

Background: Psychologists, Respiratory Care Practitioners and Clinical Social Workers license is subject to automatic revocation if there is a finding by an administrative law judge that any of these practitioners have engaged in any sexual contact with a patient, or committed an act of sexual abuse or sexual exploitation of a patient as defined in Section 729 of the Business and Professions Code, or been convicted of a sex offense as generally defined. A physician is not subject to this provision and could be allowed to continue their practice even though they have been found to be in violation of Section 729 or other sexual offense.

ISSUE #19: What action is the Board taking against unlicensed practice, especially in clinic settings, and is there a need for statutory changes dealing with the unlicensed practice of medicine and for impersonating a physician?

Question #19 for the Board: Please explain actions the Board is taking to curtail unlicensed practice, especially in health clinic settings and the need for the recommended statutory changes.

Background: The Board is currently involved in efforts to prevent unlicensed practice in health clinics primarily serving depressed socioeconomic populations. The Board is also recommending changes to two statutes involving the unlicensed practice of medicine and adopting a statute to deal with impersonating a physician.

ISSUE #20: Is there a need to increase the fine authority of the Board for cases involving financial fraud?

Question #20 for the Board: *Please indicate what particular activities or violations of the Medical Practices Act would warrant fines, and at what level should the fines be set.*

Background: The Board currently has authority to only cite and fine physicians for relatively minor offenses that do not rise to the level of formal disciplinary action. The Board is recommending that it also have authority to fine in instances where the disciplinary action involves financial fraud such as billing or insurance fraud, embezzlement and extortion.

ISSUE #21: What action is the Board taking to deal with the issue of pain management and appropriate prescribing?

Question #21 for the Board: *What action has the Board taken to assure implementation of recent legislation regarding pain management? Are there other laws or programs the Board believes necessary to deal with this issue?*

Background: Since the last sunset review, there have been a number of laws passed that relate to pain management. SB 402 (Green, Chapter 839, Statutes 1997) established the “Pain Patient’s Bill of Rights.” Physicians may refuse to prescribe opioid medication for patients who request the treatment for severe chronic intractable pain, however they must inform the patient that other physicians specialize in the treatment of such pain with methods that include the use of opiates. AB 2305 (Runner, Chapter 984, Statutes 1998) provides that physicians who are in compliance with the California Intractable Pain Act will not be subject to disciplinary action, and that medical expert reviewers retained for an investigation of complaints relative to prescribing for pain must be specialists in pain management. SB 1140 (Chapter 791, Statutes 1998) requires the Medical Board to consider including a course on pain management in CME requirements and to periodically develop and disseminate information and educational material regarding pain management techniques and procedures to physicians and general acute care facilities. AB 791 (Thomson, Chapter 403, Statutes 1999) added pain management and end-of-life care to the curriculum requirements for students entering medical school on or after June 1, 2000.

According to the Board, pain management is a topic of much debate and that there is general agreement from those within and outside of the profession that patients suffering from pain are often undertreated by physicians for various reasons, including fear of disciplinary action for excessive prescribing of opiates. Finding the balance between encouraging adequate prescribing while discouraging excessive and dangerous prescribing may have sent mixed messages to the profession. The Board indicates that it is committed to finding an appropriate balance and educating physicians so that those suffering from pain receive appropriate and adequate relief, and that it is working to expand the Board’s experts to include specialists dedicated to pain management, and is committed to working with the Legislature in drafting laws and programs to bring about positive change.

ISSUE #22: There has been a substantial increase in the use of psychiatric drugs for children, especially those diagnosed as having Attention Deficit/Hyperactivity Disorder (ADHD)?

Question #22 for the Board: *Does the Board have some concerns regarding increasing use of psychiatric drugs for children and what actions does the Board believe are necessary to assure that the overprescribing of psychiatric drugs does not occur?*

Background: Over the past five years there has been a substantial increase in the use of psychiatric drugs for school age children who are diagnosed as having ADHD. It is estimated that between 8 to 10 million children are now being medicated with Schedule II drugs, including such stimulants as Adderall, Concerta and Ritalin. Last year, physicians wrote about 20.6 million prescriptions for these types of stimulants, an increase of almost 37% since 1997. The sale of these drugs has also grown into almost a 1 billion-dollar industry in just the past five years. The pharmaceutical industry was accused this year by Drug Enforcement Agency (DEA) of using questionable practices in their advertisements of these drugs and in marketing of these drugs to physicians. Cease and desist orders were sent out by DEA to particular pharmaceutical companies for their marketing gimmickry. The Senate Business and Professions Committee will be holding a hearing on this issue on January 8, 2002, because of concerns raised by certain groups and organizations representing parents and children and health care practitioners, and numerous individuals including physicians and psychiatrists.

ISSUE #23: What has the Board done to implement recent legislation regarding plastic and cosmetic surgery and to deal with related cosmetic procedures that may be unlawful?

Question #23 for the Board: *What action is the Board taking to implement SB 836 and SB 450, and when will the Board adopt extraction and postoperative care standards for liposuction as required by SB 450? Also, what action has the Board taken regarding the use of lasers for hair removal or other type of cosmetic procedures that would be considered the practice of medicine?*

Background: There have been a number of bills to deal with problems regarding plastic and cosmetic surgery. SB 836 (Figueroa, Chapter 856, Statutes 1999) made the advertising law (B&P Code 651) more specific in order to identify and take action for misleading, and thus illegal marketing practices in the advertising of plastic and cosmetic surgery treatments. SB 450 (Speier, Chapter 631, Statutes 1999) also addressed the issue of advertising for plastic and cosmetic surgery and required the Board to adopt extraction and postoperative care standards for liposuction. There have also been instances in which the Board needed to address other related cosmetic procedures that are being used by untrained or unlicensed practitioners and involve the practice of medicine.

ISSUE #24: Why has the Outpatient Surgery Accreditation Law been difficult to implement and what further refinements are necessary?

Question #24 for the Board: *Please explain why the Board lacks sufficient evidence to clarify the existing requirement of what outpatient facilities must be accredited or promulgate more stringent regulations to raise minimum standards for accreditation, emergency plans, mandatory reporting events, and so on. Are the criteria used by accreditation agencies recognized by the*

Board consistent, and if not, should more uniform accreditation criteria be established? What actions has the Board taken against physicians in unaccredited offices and what are the number of reports the Board has received regarding deaths or transfers to hospitals pursuant to the reporting requirement of AB 271?

Background: The Board generally has no jurisdiction over facilities. Facilities, such as hospitals, clinics, ambulatory surgical centers, and certain other facilities, are under the purview of the Department of Health Services (DHS). The one exception to this is certain outpatient surgery settings engaging in some practices defined in law, performed outside hospitals and certified facilities. California has had an “outpatient surgery” law on the books since January 1, 1995, and it went into effect for physicians on July 1, 1996. AB 595 (Speier) was Board-sponsored legislation and was the outcome of the kind of horror stories found in our complaint files and media reports, mostly surrounding plastic and cosmetic procedures in physician offices and the outcome of procedures performed in unlicensed abortion clinics. The Board envisioned a law more encompassing, perhaps requiring the licensure of facilities by DHS. This was opposed, however, by DHS. The final law passed was very different than what was first envisioned by the Board. In summary, the law requires that surgery performed under a certain specified level of anesthesia, if not performed in a licensed hospital or surgery center, be done in an accredited facility. The Board does not perform accreditation, but instead delegates that function to agencies it approves. Currently, there are four viable accreditation agencies. According to the Board, the law has not provided the level of patient protection, nor given the Board the ability to act proactively as was envisioned. As indicated by the Board, the way the law is currently written has left too much uncertainty about its application unless further regulations or laws are written. The most problematic portion of the law, as stated by the Board, is the determination of who must be accredited. The Board indicates that it was granted authority to promulgate regulations to further strengthen the law, but that it lacks sufficient evidence to promulgate more stringent regulations.

ISSUE #25: What steps is the Board taking to deal with the changing and emerging treatment modalities in the practice of medicine, including those associated with “alternative medicine?”

Question #25 for the Board: *Please explain what steps the Board has taken to deal with the requirements of SB 2100. What guidelines is the Board considering and when will they be adopted, and does the Board anticipate regulations to be adopted as well?*

Background: In 2000, the Legislature passed SB 2100 (Vasconcellos, Chapter 660), the Alternative Medical Practices and Treatment Act. It required the Board to address the emergence of holistic health and consider whether steps should be taken to redesign their systems to meet the healthcare needs of those seeking alternative medical treatment. It also required the Board to establish disciplinary policies and procedures by July 1, 2002, to reflect emerging and innovative medical practices. To meet this mandate the Board formed an “Alternative Medicine Committee.” The Board indicates that its Alternative Medicine Committee is considering some guidelines for practitioners wishing to use non-conventional

methods of practice and disciplinary and investigative guidelines for cases involving alternative medicine.

DIVERSION PROGRAM ISSUES

ISSUE #26 Why was a plan not provided to the Legislature to privatize (contract out) the Board's Diversion Program? What reforms have been made to the current Diversion Program? Should the Board continue to maintain and operate its own Diversion Program?

Question #26 for the Board: *Why was a plan not provided to the JLSRC and Department to privatize the Diversion Program? What specific changes and reforms have been made to the current program to treat and monitor participants in the program, and ensure protection of the public from physicians who are impaired due to abuse of alcohol or other drugs, or due to mental or physical illness?*

Background: At the last sunset review, the Department and the JLSRC voiced concerns about the Board's Diversion Program which monitors licensees with substance abuse problems, and occasionally, mental illness. As indicated by the JLSRC, California appears to be one of only two state medical Boards that operate its own diversion program. (With a total of about 10 states having any form of officially sanctioned diversion program.) The costs of California's diversion program had been steadily increasing, up to \$786,000 for FY 96/97, yet the success rate had been decreasing, down to 16% of those who participated in FY 96/97. The JLSRC found that since the inception of the program in 1980, there have been about 800 participants, with 564 (69%) successfully completing the program - which requires two or three years of counseling and an alcohol or drug free rehabilitated lifestyle. Of the 564 "successful" participants, as of December 31, 1996, 38 participants (or 6.7%) had re-entered the diversion program. The Board reported that there were about 213 active participants in its diversion program in FY 96/97, with 35 physicians successful completing the program during that fiscal year, and 21 unsuccessfully leaving the program. The Board noted that a 1991 study indicated that participants who successfully completed the program had fewer complaints (4%) than the average for all licensed physicians (7%). Participants paid \$235 per month to participate in twice-weekly group counseling sessions and also paid an additional \$43 for two urine tests conducted each month. The Board argued, that the benefits of the program are in providing rehabilitation to the impaired physician while protecting the public from harm, all at a cost far less than what it might otherwise take to discipline the physician for a violation.

Criticisms of the program included: (1) that it unreasonably diverts physicians from the Board's disciplinary process; (2) that it should not be operated by the Board, but instead by an entity in the private sector separated from the Board (reducing the licensees fear of disciplinary action thereby); (3) conflict of interest on the part of program staff (e.g., group counselors) who are paid \$235/mo. by participants (allegedly encouraging participant retention despite violations of the conditions of program participation); and, (4) the inability of the program to actually monitor a participating physician's compliance with agreed-to practice restrictions or cessation.

Given what was the Board's projected deficit at that time, its increasing enforcement costs, the high cost to the Board to operate this program (about \$800,000 out of a budget of \$31 million), the relatively low number of program participants (particularly compared to the likely number of impaired physicians generally), and the "success" rates – the JLSRC and Department questioned whether the Board should continue to operate this program. The JLSRC recommended that the Board in conjunction with other boards utilizing the Diversion Program to report to the JLSRC on September 1, 1999, on a plan to privatize the Diversion Program.

In response to this request and other concerns raised by the Department and JLSRC, the Board formed a Diversion Task Force in February 1998, and undertook an extensive review of the operation of the Program. The issue of privatization of the Diversion Program was discussed and then rejected by the Committee. However, the Board indicates that a number of reforms have been made to the current Diversion Program to ensure public protection.

It is unclear whether the reforms of the Diversion Program have addressed all of the concerns raised during the last sunset review. The costs of this program continue to rise. It cost the Board \$936,000 to provide this program in FY 2000/01. There were about 273 active participants in the program as of June 30, 2001, and approximately 49 successful candidates in 1999/00. (Over the past eight years there has been about 35 successful candidates per year.)

ISSUE #27: Should the Board be able to compel a competency examination for participants within the Diversion Program?

Question #27 for the Board: *Under what circumstances would the Board require a competency examination for those participating in the Diversion Program?*

Background: The Board is concerned that physicians participating in the Diversion Program may be out of practice for some time and may not be current in medical practice skill or training. The Board recommends that they be given the authority to require a competency examination to ensure that the physician can safely practice when deemed appropriate from a rehabilitation perspective.

PUBLIC INFORMATION, DISCLOSURE REQUIREMENTS AND ACCESS OVER THE INTERNET ISSUES

ISSUE #28: There have been concerns raised about the adequacy, content, quality, format and timeliness of information provided by the Board to the public.

Question #28 for the Board: *What efforts and improvements has the Board made to information it makes available to the public regarding the Board and the licensees that it regulates? What changes to the Board's disclosure requirements are anticipated or will be discussed and what other ways is the Board considering to provide more useful and meaningful information to the public?*

Background: From August to October 1999, and subsequently in January 2000, the Public Citizen's Health Research Group (HRG) surveyed 51 boards that regulate medical doctors to determine what type of information was made available to the public over the Internet. In what format is it presented? How complete and current is it? How does it compare to the disciplinary information a consumer can get by calling the board? The HRG created a grading scale to assess the adequacy of information provided over each of the web sites it reviewed. Out of a possible A to F grade, the California Medical Board received a grade of "D." The HRG also categorized web sites as either user-friendly or not. The Medical Board's web site was considered as user-friendly.

There have also been questions raised about how soon in the disciplinary process information should be made available to the public and if reportable information to the Board, such as malpractice settlements, should also be disclosed to the public. The Board indicates that it has established a "Committee on Public Information Disclosure" to discuss the issues surrounding the information it provides to consumers, how it might be made more meaningful to consumers, and what modifications should be made to current law or policy.

ISSUE #29: Have there been any delays in providing information to the public as required by legislation over the past four years?

Question #29 for the Board: *When did the Board begin notifying physicians of the requirements to provide this information required by legislation and what methods are used by the Board to ensure physicians are properly notified of the information that must be provided pursuant to this legislation? Is this information made available to the public over the Board's website?*

Background: AB 833 (Ortiz, Chapter 754, Statutes 1997) requires doctors performing an annual gynecological examination to provide patients a published summary of a description of the symptoms and appropriate methods of diagnoses of gynecological cancers. It also required the Department of Health Services to develop a plan for the distribution of these materials. SB 1 (Burton, Chapter 11, Statutes 1997) requires a physician examining a patient's prostate to provide information about the availability of appropriate diagnostic procedures, including the prostate antigen test. SB 402 (Green, Chapter 839, Statutes 1997) requires physicians who refuse to prescribe opioid medication for patients who request treatment for chronic intractable pain, to inform the patient that other physicians specialize in the treatment of such pain with methods that include the use of opiates.

**USE OF THE INTERNET BY PHYSICIANS AND PATIENTS FOR
DIAGNOSIS AND TREATMENT AND OBTAINING MEDICATIONS**

ISSUE #30: Does the Board still anticipate that a registration program will be needed to deal with Telemedicine practice in California?

Question #30 for the Board: *Does the Board anticipate that there may be a need for such a registration program in the future and that the federal government may take action in this area? Are there still concerns regarding this type of practice and in protecting the public from certain aspects of telemedicine practice within California?*

Background: The Federation of State Medical Boards has proposed that all states provide a registration program in-lieu of licensure to enable practitioners to practice over state lines via technology. Pursuant to SB 2098 (Kopp, Chapter 902, Statutes 1996) the Board was given authority to work with interested parties and propose legislation later regarding a registration program. The Board formed a “Telemedicine Committee” and began discussions regarding a registration program. The most outspoken opponents to a registration program was the California Medical Association. As indicated by the Board, little has changed since those discussions. There appears to be no demand for such a program and the same opposition exists.

ISSUE #31: What actions has the Board taken regarding the unlawful prescribing and dispensing of drugs over the Internet?

Question #31 for the Board: What actions has the Board taken to deal with what may be the unlawful prescribing and dispensing of drugs over the Internet. Are there other modifications to the laws that may be necessary to deal with this problem?

Background: The Board has appointed a “Teleprescribing Committee” to deal with issues involving both the prescribing and dispensing of drugs over the Internet, especially from states outside of California. The Board indicates that it must work with the Pharmacy Board, the Attorney General and appropriate federal government agencies and other states for enforcement action.

4.

**FINAL RECOMMENDATIONS OF THE JOINT
LEGISLATIVE SUNSET REVIEW COMMITTEE AND THE
DEPARTMENT OF CONSUMER AFFAIRS**

ISSUE #1: (REVIEW BARRIERS TO RESIDENCY AND LICENSURE FOR INTERNATIONAL MEDICAL GRADUATES?) Should the Board continue its involvement in issues related to physician shortages and providing health care for low-income consumers living in medically underserved areas?

Recommendation #1: *The Joint Committee and the Department recommend that the Board designate a staff liaison to work with International Medical Graduates (IMGs) and programs that assist them.*

Comments: The Board has established itself as a leader within the Department's regulatory culture. Beginning in 2001, the Board's Executive Officer has made significant contributions to the work of the Task Force on Culturally and Linguistically Competent Physicians and Dentists. As the Task Force examines issues pertaining to the need to increase access to health care for low-income consumers living in medically underserved areas, much of the discussion came back to questions about the licensure process for physicians and discussion of possible changes to that process. The participation of the Board's Executive Officer and the Board's advice in these discussions has been critical to Task Force deliberations and has been recognized by the members of the Task Force as key to thoughtful resolution of matters before the Task Force.

The Task Force has held five public hearings in communities throughout the State to assess consumers need for providers who are culturally and linguistically competent.² In each of these communities, the Task Force has heard from International Medical Graduates (IMGs) who wish to practice as physicians in the U.S. and have demonstrated competence by passing the United States Medical Licensing Examination (USMLE), but are unable to secure a residency position necessary for licensure. With the assistance of the Medical Board, the Task Force intends to look more closely at the barriers to residency and licensure encountered by IMGs. The Department recommends the Board designate a staff liaison to work with IMGs and the programs devoted to facilitating their licensure and re-entry into their profession. The Department commends the Board for its willingness to examine these issues and looks forward to continuing its collaborative work.

ISSUE #2: (CREATE PROGRAM FOR AFFILIATED HEALTH CARE PROFESSIONS?)

Is it appropriate for the Board to continue regulating other health care professionals who are not physicians and surgeons or should these professions be regulated by another entity under the Department?

Recommendation #2: *The Joint Committee and the Department recommend that the feasibility of regulating affiliated healing arts professionals by another regulatory entity should be examined and an outside consultant should be retained to study the feasibility of establishing such an entity.*

² San Diego, Salinas, Oxnard, San Francisco, Sacramento and Bell Gardens, California.

Comments: The Department concurred with the JLSRC's preliminary recommendation that the time has come to explore the feasibility of establishing a program for affiliated healing arts professionals, including licensed midwives, registered dispensing opticians and research psychoanalysts. Recognizing the limited resources of the Board, as well as the challenges associated with undertaking regulation of specialized professions, it is appropriate to consider moving non-physician licensees to another regulatory venue. The Department recommended that an outside consultant be retained to study the feasibility of establishing such an entity.

ISSUE #3: (STREAMLINE LICENSING REQUIREMENTS FOR STATE OR FEDERAL EMERGENCIES?) Could licensing and fee requirements be changed so physicians in retired or inactive status, or whose license has lapsed, could be utilized for state or federal emergencies?

Recommendation #3: *The Joint Committee and the Department recommend streamlining licensing and fee requirements for physicians and retired/inactive licenses, enabling them to practice in a state or federal emergency.*

Comments: The Board should allow physicians with lapsed licenses to request a retired license status without being required to pay the license fees plus delinquent fees for the years their license lapsed. Currently, when physicians retire, they are entitled to request that their license be retired, placing them in a fee exempt license category which allows them to continue to practice as long as they continue to fulfill the continuing education requirements.

Making this statutory change would enable retired physicians to reactivate their licenses quickly in the event of a physician shortage caused by a state or federal emergency. In light of recent events, the Board should streamline the process for retired physicians to return to practice if their skills are needed.

ISSUE #4: (AUTOMATICALLY REVOKE LICENSE OF PHYSICIAN WHO SEXUALLY ABUSED A PATIENT?) Should the license of a physicians be automatically revoked if they are found to have engage in any sexual exploitations of a patient?

Recommendation #4: *The Joint Committee and the Department recommend that a physician's license should be subject to automatic revocation if found to have sexually abused, exploited or engaged in sexual contact with a patient and should not be subject to reconsideration by the Board.*

Comments: Business and Professions Code Section 729 subjects the licenses of psychologists, respiratory care practitioners and clinical social workers to automatic revocation if there is a finding of sexual abuse. This provision should be applied to physicians. Abuse of the patient/physician relationship is an egregious violation of trust and should have severe consequences. In the rare instance that a physician sexually abuses or exploits a patient under his or her care, the physician should lose the right to practice.

ISSUE #5: (COMPEL COMPETENCY EXAMINATION FOR DIVERSION PROGRAM PARTICIPANTS?) Should the Board be able to compel a competency examination for participants within its Diversion Program to assure they are current in medical practice skills and training?

Recommendation #5: *The Joint Committee and the Department recommend that the Board should have the authority to require a competency examination of physicians participating in the Diversion Program.*

Comments: Physicians participating in the Board's diversion program for an extended length of time that have been out of touch with patients may not have the current clinical skills needed to return to practice. In order to guarantee that all licensees are providing a high standard of care to consumers, the Board should have the authority to require a competency examination before allowing the physician to return to practice.

ISSUE #6: (ENACT REGULATIONS TO CLARIFY PHYSICIAN SUPERVISION OF MIDWIVES?) Should the Board promulgate regulations to define and implement the requirement for physician supervision of licensed midwives consistent with recent interpretations of the practice of midwifery in California?

Recommendation #6: *The Joint Committee recommends that a midwifery model should be used in determining the standard of care for midwives and the appropriate level of physician supervision.*

Comments: Since the passage of the Licensed Midwifery Practice Act in 1993, tension has existed between the physicians and the midwives, both of whom are licensed by the Board. The scope of practice of midwives authorizes them to attend home deliveries, practicing under the supervision of a physician. Unfortunately, due to liability concerns, no physicians are willing to provide the required supervision to a midwife. As a result, licensed midwives are disciplined by the Board when they attend a home birth regardless of the outcome of the birth. This action has had a chilling effect on licensed midwives and has reduced the number of practitioners available to women who choose to give birth at home.

To remedy this situation, the Department concurred with the JLSRC's preliminary recommendation that the Board should promulgate emergency regulations to clarify that in disciplinary proceedings a midwifery model of care, as defined in the Osborn decision³, rather than a medical model of care be used to determine the appropriate standard of care for midwives. Additionally, the Board should define in regulations the appropriate level of physician supervision that is necessary and consistent with the intent of the Licensed Midwifery Practicing

³ Accusation against Alison Osborn, L.M. before the Division of Licensing, Medical Board of California. OAH No: N-1999040052

Act. Pending this action by the Board, no further disciplinary action should be taken against midwives who lack physician supervision, absent evidence of other violations.

ISSUE #7: (CONTINUE WITH REDESIGN OF THE LICENSING PROGRAM?)

Should the Board continue its efforts to redesign its licensing program to deal with substantial delays that occurred in the licensing of physicians during the year 2001?

Recommendation #7: The Joint Committee recommends that the Board should continue to implement recommendations of the Cooperative Personnel Services (CPS) of Human Resource Services to redesign its licensing program.

Comments: In 2001, substantial delays were encountered in the licensing of new physicians. The Board has recognized that there is a growing application workload that may result in further delays in the future if adjustments and improvements are not made to address it. To obtain an objective assessment of the Board's Licensing operations, and to solicit expert recommendations for remedies of the problems being experienced, in 2001, the Board contracted with CPS Human Resource Services. In June, after evaluating the processes of the program, as well as interviewing staff and managers, CPS made a number of observations and recommendations.

ISSUE #8: (IMPROVE LICENSING RECIPROCITY AND PORTABILITY?) Should the Board continue its efforts to improve on licensing reciprocity and portability for applicants from other states and countries?

Recommendation #8: The Joint Committee recommends that the Board should continue with its efforts to implement changes to enhance license portability and reciprocity for physician applicants from other states and countries and should be granted authority initially to waive clinical requirements for out-of-state applicants based on specified criteria.

Comments: There are discussions which continue at the national level to explore mechanisms that could significantly improve the portability of state medical licensure, including licensure by endorsement and removing certain barriers to reciprocity between states in order to improve the ability of physicians to practice in other states. The Board continues to participate in those discussions and has been actively involved efforts to provide healthcare access to populations within California who traditionally experience either no care, or substandard medical care because of language or cultural barrier.

The Board has initially recommended changes to the strict clinical requirements for applicants from other states. As indicated by the Board, the specificity of the licensing law has created unintended delays for some qualified applicants who have practiced in other states, frequently, board-certified physicians, who trained many years ago when certain elements of their training differ from today's medical curriculum. The differences in their training is not substantial, and does not imply that they are not fully qualified to practice in California. Business & Professions Code Sections 2089.5 & 2089.7 not only requires adequate training in enumerated subjects, but specifies the actual amount of weeks of training in certain subjects. As an example, a board-

certified neurosurgeon from Illinois, trained in the 1970s, may have trained five weeks in pediatrics and eight weeks in obstetrics and gynecology, which would be one week short of the six weeks required in pediatrics and two weeks over the required six weeks of OB/GYN. Under the current law, the Board has no discretion to certify that the applicant has substantially met the requirements for licensure, and the neurosurgeon would be forced to find a training program to provide the additional training in pediatrics. While there is certainly a good rationale for requiring the weeks of training outlined in most cases, in some, it is merely a unnecessary and unreasonable obstacle that delays the entry of qualified physicians to California.

It would appear reasonable and desirable to grant the Board's Division of Licensing the authority to determine the qualifications for licensure of those applicants who have maintained an unlimited and unrestricted license in another state for at least 10 years, but who lack a small measure of the existing clinical requirements.

ISSUE #9: (SHOULD POSTGRADUATE TRAINING BE INCREASED BY ONE YEAR?) Should the current requirement for postgraduate training for U.S. graduates of medical school be increased from one year to two years?

Recommendation #9: *The Joint Committee recommends that the Board should provide results of a study it is conducting to the JLSRC and the Department prior to any effort to increase postgraduate training by one year.*

Comments: One year of postgraduate training in an approved postgraduate training program is required for U.S. graduates and two years for international graduates. Nationally, there is some variability with many states requiring two or three years. The Federation of State Medical Boards has adopted a position that full licensure should be delayed until a third year of postgraduate training and urges all states to adopt this standard. During the last review, the JLSRC recommended that the Board not increase postgraduate study to two years because of lack of justification. The Board is currently involved in a study to determine if an additional year of postgraduate training should be required before licensure.

ISSUE #10: (CONTINUE WITH STUDIES AND PROJECTS TO IMPROVE QUALITY AND SAFETY OF HEALTHCARE FOR PATIENTS?) Should the Board continue with its efforts to study and implement programs to improve the overall quality and safety of healthcare received by patients?

Recommendation #10: *The Joint Committee recommends that the Board should continue to: (1) implement the Practitioner Remediation to Enhance Patient Safety (PREPS) Project; (2) complete its study regarding physician discipline and its link to medical school professionalism problems; (3) continue its participation in the University of California program to develop patient safety models for its medical centers; and, (4) complete its study on risk factors for physicians discipline. It should also continue to participate in other programs, projects or studies that could potentially improve the overall quality and safety of healthcare for the public.*

Comments: The Board has indicated that they are involved in several studies and projects to enhance the quality and safety of healthcare and to reduce medical errors and occurrence of patient harm.

ISSUE #11: (CHANGES TO THE BOARD’S CME PROGRAM?) Are changes needed to the Board’s continuing medical education (CME) program?

Recommendation #11: *The Joint Committee recommends that the Board should provide results of its study of the CME program and recommendations on any changes that are necessary to improve the overall quality of the program by March 2003.*

Comments: The requirement for CME is a long-standing feature of physician licensing. To ensure that physicians keep pace with the changing and complex field of medicine, the Board requires completion of an average of 25 hour of approved CME each year and a minimum of 100 hours every four years. A random audit of the licensee population is conducted each year to verify compliance with the CME requirement; those found not to be in compliance are subject to citations and fines. The Board indicated that it has made no changes in its CME program since its last sunset review, but indicates that is currently engaged in a study designed to determine if there are ways to enhance continued knowledge and competency of physicians.

ISSUE #12: (INCREASE PENALTY FOR UNLICENSED PRACTICE?) Should the penalty for practicing without a license be increased from a misdemeanor to a “wobbler” and impersonating a physician be a criminal sanction as recommended by the Board?

Recommendation #12: *The Joint Committee recommends that Section 2052 of the Business and Professions Code should be changed to a “wobbler” (allowing the charging of a felony or misdemeanor) and impersonating a physician should be a criminal sanction.*

Comments: At present, practicing medicine without a license is a misdemeanor if there is no harm to the patient/victim. Section 2053 of the B&P Code allows for the charging of a felony if there is great bodily harm or potential for great bodily harm. The reality is that prosecutors will not charge a felony violation unless there is great bodily harm. For minor violations, a misdemeanor is appropriate. For more egregious violations, such as a recent case portrayed in “48 Hours,” a felony would be more appropriate. (In this instance, the person posed and practiced as a doctor many times, and in one instance his lack of providing appropriate treatment resulted in the death of a patient. As a practical matter, changing Section 2052 to a “wobbler” would give the Board and prosecutors greater flexibility. The Board also indicated that impersonating a physician is not a crime. It is the opinion of the Board that there should be some criminal sanction for impersonating a physician.

ISSUE #13: (ALLOW FINANCIAL PENALTY FOR DISCIPLINARY CASES INVOLVING FRAUD?) Should a financial penalty be allowed when there is a finding of fraudulent activity on the part of the physician?

Recommendation #13: *The Joint Committee recommends that the Board should be granted authority to assess a financial penalty for disciplinary cases which involve fraudulent activity on the part of the physician.*

Comments: As recommended by the Board, fine authority involving financial fraud should be utilized as part of the formal disciplinary action, and a part of the Board's current citation and fine program. Crimes included involve high stakes financial return from fraudulent activity, such as those surrounding insurance or worker's compensation fraud, selling fraudulent treatment or medicines to unsuspecting patients, of "fronting" for other practitioners involved in fraudulent practices. All of these activities, especially if severe, will likely result in severe disciplinary action, but under the current system, the perpetrator of the fraud may keep his or her ill-gotten profit. Allowing, through the administrative process, as explained by the Board, an assessment of a financial penalty two or three times the amount gained through fraudulent activity would appear just. (Especially in light of the reality that generally the amount of fraud discovered or the amount subject to prosecution is often less than the actual total of the gain.)

ISSUE #14: (ADOPT DISCIPLINARY POLICIES AND PROCEDURES REGARDING THE PRACTICE OF ALTERNATIVE MEDICINE?) Should the Board adopt disciplinary policies and procedures relating to the practice of alternative medicine and also assess the need for specific standards for investigations of those involved in alternative practice?

Recommendation #14: *The Joint Committee recommends that the Board should ensure that disciplinary policies and procedures are adopted to reflect alternative medical treatment and practices by July 1, 2002, and should provide the JLSRC with a copy of those policies and procedures, as well as with evidence of the discussion and assessment of the need for standards of investigation for those involved in the practice of alternative medicine, what recommendations were made, and what action the Board has taken pursuant to those recommendations.*

Comments: In 2000, the Legislature passed SB 2100 (Vasconcellos, Chapter 660), the Alternative Medical Practices and Treatment Act. It required the Board to address the emergence of holistic health and consider whether steps should be taken to redesign their systems to meet the healthcare needs of those seeking alternative medical treatment. It also required the Board to establish disciplinary policies and procedures by July 1, 2002, to reflect emerging and innovative medical practices. To meet this mandate the Board formed an "Alternative Medicine Committee." The Board indicates that its Alternative Medicine Committee is considering some guidelines for practitioners wishing to use non-conventional methods of practice and disciplinary, and investigative guidelines for cases involving alternative medicine.

ISSUE #15. (FURTHER REFORMS NECESSARY TO THE DIVERSION PROGRAM?)

Should other changes and reforms be made to the current Diversion Program of the Board?

Recommendation #15: *The Joint Committee recommends that the enforcement program monitor shall evaluate both the effectiveness and efficiency of the Board's current Diversion Program and make recommendations to the JLSRC and Department regarding the continuation of this program, and any changes or reforms which should be made to ensure that participants in the program are appropriately monitored, and to ensure protection of the public from physicians who are impaired due to abuse of alcohol or other drugs, or due to mental or physician illness.*

Comments: At the last sunset review, the Department and the JLSRC voiced concerns about the Board's Diversion Program which monitors licensees with substance abuse problems, and occasionally, mental illness. As indicated by the JLSRC, California appears to be one of only two state medical boards that operate its own diversion program. (With a total of about 10 states having any form of officially sanctioned diversion program.) The costs of California's diversion program has been steadily increasing, from \$786,000 in FY 1996/97 when last reviewed, to \$936,000 in FY 2000/01. There were about 273 active participants in the program as of June 30, 2001, and approximately 49 successful candidates in 1999/00. (Over the past eight years there has been about 35 successful candidates per year.)

Criticisms of the program included: (1) that it unreasonably diverts physicians from the Board's disciplinary process; (2) that it should not be operated by the Board, but instead by an entity in the private sector separated from the Board (reducing the licensees fear of disciplinary action thereby); (3) conflict of interest on the part of program staff (e.g., group counselors) who are paid \$235/mo. by participants (allegedly encouraging participant retention despite violations of the conditions of program participation); and, (4) the inability of the program to actually monitor a participating physician's compliance with agreed-to practice restrictions or cessation.

In response to the concerns of the JLSRC and Department, the Board formed a Diversion Task Force in February 1998, and undertook an extensive review of the operation of the Program. The issue of privatization of the Diversion Program was discussed and then rejected by the Committee. However, the Board indicated that a number of reforms were made to the current Diversion Program to ensure public protection. It is unclear at this time, however, whether the reforms of the Diversion Program have addressed all of the concerns raised by this committee during the last sunset review.